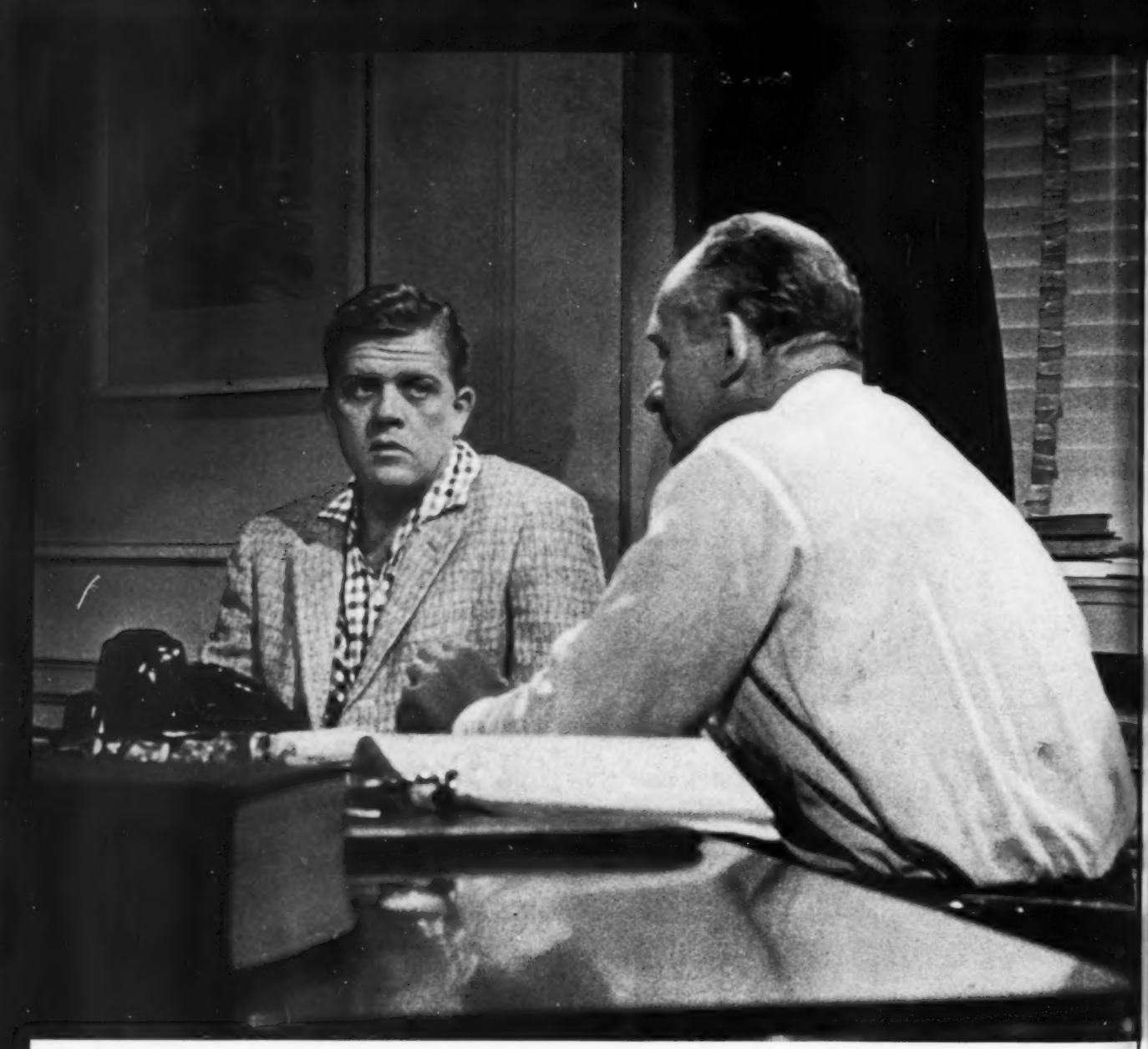
Mental Hospitals

FEBRUARY 1959

TENTH MENTAL HOSPITAL INSTITUTE PROCEEDINGS



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Mental Hospitals

VOLUME 10 NUMBER 2

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TENTH MENTAL HOSPITAL INSTITUTE ISSUE

ACADEMIC LECTURE

The Academic Lecture, "Psychological Factors in Space Flight," which was delivered by Capt. Norman Lee Barr, MC, USN, is being published separately as Monograph Series No. 5. A copy will be sent to each person who attended the Institute. The Monograph will also be included in the February supplementary mailing for subscribers to the Mental Hospital Service.

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THE MANY THREADS OF SERVICE

Address delivered at the Tenth Mental Hospital Institute Banquet

By Dr. FRANCIS J. GERTY

President, American Psychiatric Association

THE PRESIDENT of the American Psychiatric Association is expected to travel about the country and say something that is stimulating eight or ten times a week—an impossible task!

I wrote to Dr. Wittson asking for some advice about what I might say tonight, and he replied "Talk about the philosophy of teaching and learning in connection with the problems of training and service."

He pointed out that your first five plenary sessions were to be devoted to the problems of personnel, including the changing needs caused by changing concepts of patients' needs.

I have consented to talk on this subject but there are difficulties in the way. It is evident that the philosophy and basic ideals are often not easily related to current pressing needs. First we have to map hopefully the road to a land we have not yet discovered or explored sufficiently. Next we have to push against the jostling crowd which is trying to satisfy its own immediate needs, and manage somehow or other to command its attention, gain its trust, and to achieve its leadership.

Dr. Simon put the matter very well when he spoke of conceptualization and implementation this morning. There is a gap which we must bridge between these two.

Dr. Rome, in speaking of the changes in the world and the changes in its needs, drew attention sharply to the fact that special procedures and special remedies, no matter how well they may seem to fit some present need, do little to remedy general conditions. They may hasten the rate of change, then tend to become obsolete and reveal new needs.

Much was said this morning about the effects of the fixed plan of organization, the impossibility of setting standards that will be a permanent expression of the epitome of standards, of the problems connected with the inspection and accreditation of hospitals, and of guarding the hospital's place as an agency of the community.

The general idea was that people, their motivation and their training, have the most to do with meeting needs, and correcting bad conditions.

Now Dr. Wittson suggests that we should summon the clouds of philosophy over the landscape and induce them to shower the rain of education, so that the crop of learning will provide sustenance for the future. This is my assignment.

I have never functioned as a rainmaker, and my efforts may only serve to make you weep. I fear that they may have more to do with problems than solutions. I hope, however, that they will emphasize at least two ideas.

Never in the history of our race have the community and the hospital been so close together as they are today, yet in view of the needs they should be closer. These two facts—the closeness and the need to be closer—have much to do with our current mental health problems. The closeness I speak of refers to all hospitals, most particularly to the general hospitals, but increasingly to special ones—including mental hospitals.

TWO REACTIONS toward the weak and the sick have always been noted in man's society; on the one hand, rejection; on the other, loving acceptance of the task of giving aid and succor.

Acceptance has rarely been loving and complete. It is of many degrees and shades, including much of rejection, the constrained acceptance given by duty and tinctured by fear and guilt, and by the thought of service as a penance. The rejection tends to increase the chronicity of diseases and the inadequacy of remedies.

Yet I would ask you to pause to think of the general hospitals of 1750 and 1850 from the time of John Hunter to that of Florence Nightingale. The private general hospital, as we know it, did not exist then.

Some of you who are interested in the historical aspects of medicine have probably read of the history of St. Bartholemew's Hospital, St. George's Hospital, and other hospitals in London. You have learned of the terrible ordeal that patients in these hospitals passed through, especially in what were called the "cutting wards;" the awful conditions that existed in time of pestilence; the terrible procedure of cutting for the stone. These places were the ones to which the public did not willingly go. Our mental hospitals of the present day are really paradises of treatment compared to what those hospitals were at that time.

Now think of the general hospitals which dot the land today, and of their relations to the community today, as compared with the relations of those hospitals of two centuries ago, up until one century ago, and even well into the end of the 19th Century. And I am speaking of general hospitals.

You note that today their location is often in the best places in the community. They are costly. They are of fine appearance. They enjoy community support and a very great measure of community use—sometimes, it is thought, more measure of this use than they really should.

The effort to make facilities correspond to those of the community life are everywhere apparent. The general

hospitals have their shops, their restaurants, and everything else arranged to make them comfortable and pleasant. There is a free interchange with the community by visiting. A great variety of services is offered for outpatients and inpatients. The staff is derived from the community. It is connected with the community by insurance, and now government support is to come for the great general hospitals.

Some of the reasons for this close relationship are implicit in the description I have already given. They meet a need. The hospital is for the community, used by the community and is part of the community. Behind this is what the general hospital offers, based on the advances of medical science and art, advances that have totaled a very great deal since the day when the surgeons were barbers and the internists were metaphysicians.

Turn your attention now to our special mental hospitals. Strengthening of community relationships is evident here, too, but not yet to the point observed in the general hospitals. The reasons for the desirability of a close relationship are probably quite apparent to you.

First, I think we should say something about the nature of mental illnesses. We have gone through a long series of changes with reference to our knowledge of their nature. In the memorials addressed to the State Legislatures of a century ago appealing for the establishment of mental hospitals, we spoke of a single disease that legislator and the general public would understand—insanity. Today we do not think of insanity as comprising mental illness.

But we must in all fairness say that there have been fewer basic advances in medical knowledge in the treatment of mental diseases than in the treatment of some other conditions. Some of you, of course, may be inclined to debate this point with me, and I think the day will come when there will be no need to debate such a point. But at present, I think I must hold to the statement which I have made.

Attitudes have also kept the community and the hospital from being as close as they should. Attitudes are very important things, even though the word is quite inadequate to express the dynamic nature of what I mean.

Our attitude appears in our terminology, in the very names that we apply to our hospitals. Originally they were called asylums. They were called hospitals for the insane. Now they are state hospitals.

The general public, too, reflects an attitude. In speaking of mental illness, they still somewhat prefer the term "nervous breakdown" and many a patient will say to you, "Doctor, isn't this nerves?"

Again we have reflection of attitudes in the laws and the regulations which govern the operations of our hospitals. Here we inherit something from the past which makes it difficult, because we set these laws and regulations when we were somewhat inexperienced.

In my own state of Illinois in 1851, the year the first state hospital was opened, a law was passed which permitted a husband to take his wife to the hospital for treatment without further legal procedure, merely on his application. Remember, this was in the day when women did not enjoy suffrage and were not eligible for public office. The legislators were thinking merely that Dorothea Lynde Dix had told them how the mental hospital would cure mental disease. Their thought was that access to the hospital should be made just as easy as possible. This was the reason for the law.

Under this law a Mrs. E. P. W. Packard was admitted to the Illinois Asylum for the Insane at Jacksonville. Between 1864, when she was discharged after three years in the hospital, and 1875, she went from state to state causing repeal and revision of the statutes designed under the guidance of Dorothea Lynde Dix for the governance of hospital treatment for the mentally ill. This she did in the name of protection of personal liberty. We still are troubled in a very real way in our attempts to provide prompt and adequate care for these sick persons by the all too stringent provisions of Mrs. Packard's personal liberty statutes.

Another reason for the separateness, the difficulty of uniting the community with the hospital in its work, is that of physical isolation. We used to think it well that patients with mental difficulty should be separated from the place where that mental difficulty began.

However, the picture is not all bad. There are evidences of closer relationship developing. De-isolation is taking place. The changes in the approach to treatment have had much to do with this. One of the early signs of the beginning of the end of isolation was the establishment of the cottage plan toward the end of the last century.

Another change which has been going on, which is really a return to the past, is the smaller hospital. Of late years we have been experimenting with the open hospital. At one time, too, the hospital community prided itself on its farm. Now the farms are going. All of these things represent a trend of the hospital returning toward the community.

The means of treatment have improved also as far as particular remedies are concerned. At this point I must speak a word of caution as to generalizing the results of some special forms of treatment. There is a rather too easy inclination to believe that they will cure all mental illness.

Attitudes, in short, have changed very considerably. This, I think, is demonstrated particularly by the growth of public interest in mental hospitals and the establishment of national and local mental health associations.

Psychiatric community practice is helping to break down the barriers—so are research, the auxiliary professions, and communications.

If you grant that the original thesis has been established, the thesis that the mental hospitals, including state hospitals, are closer to the community than ever before, what should be the next few steps so that the hospital and the community operate together and function still more efficiently?

This, more than is generally supposed, is more closely related to education and learning than it is to organization and training. In other words, conceptualization with its aids, exploration, thought and experiment, must be given full scope before implementation and application in training procedures.

Let us examine briefly some of the old ideas of organization and training, and see what we think of them now. We may start with the state hospital itself.

Its establishment was based on claims of knowledge as to how the disease "insanity" could be cured. We do not approach the matter in that way now. There is emphasis now on different treatments for differing mental illnesses. There is in this recognition that adequate diagnosis is a necessary preliminary for adequate treatment. I wonder how many of you who have finished your psychiatric training within the last fifteen years, have had much to do with hydrotherapy in a hospital? I well remember when Dr. Samuel Hamilton visited me at Cook County Psychopathic Hospital, and, noticing a top canvas over the hydrotherapy continuous bath tub, insisted that it be taken off because this was a means of restraining the patient.

The shifting of the treatment burden to the state, I think, deserves some remark. It tended to separate the local community activities from those of the state in mental illness treatment from the beginning of the movement to establish state hospitals.

This may seem to be meaningless to you. To me it is a thing of which I am very acutely aware. In Cook County in 1912 we had two institutions, a detention hospital, and an infirmary. The latter included the asylum for the insane. The local community, the county, took care of its mental patients. In 1912 there was a deal between the county authorities and the state authorities. While I dislike the word "deal" in this connection, it is probably suitable here. The county agreed that it would give the land and the buildings of the infirmary to the state for a state hospital, if the state would agree to undertake the whole treatment of the mentally ill while the county would assume responsibility only for temporary detention of mental patients pending their trial in the county court to determine whether they should or should not be committed to the state hospital.

Obviously, this was a step in the wrong direction. We are now taking what I call the long way back through Federal support. I call it the long way back because taxes that are collected locally are routed to Washington and then redistributed to all parts of the country to help promote community services. It is the long way around, and in principle not the best way, but I think we must be very thankful that we have this indirect way back to the communities. Further, we should be thankful that it is so well administered by Dr. Robert H. Felix and Dr. Robert T. Hewitt of the United States Public Health Service.

At the present time we are engaged in a conflict which has a bearing on the matter of community service as rendered by mental hospitals. I refer to some of the problems that have arisen between the A.P.A. Central Inspection Board and the Joint Commission on Accreditation of Hospitals. I shall touch on the matter a little later.

These are only a few examples of organizational problems and their possible solutions. Under each heading, more could be listed. All of the problems, I think, come from fixity of organization, fixity of standards, rule-books administration, and what I might call drilling and training instead of thinking and learning.

Let us consider philosophy and learning as it connects with this.

Since I am on a philosophical expedition, I will give you my thoughts impressionistically. As I sit in my balloon, floating in and out of philosophical clouds, trying to decide where to plant the ice seeds that will make the rain fall, I get a view of the landscape beneath.

There are towns and villages, farms, cities, and here and there state hospitals, their battlemented walls having fallen somewhat into a state of ruin.

There are railroad tracks, not many interurban electric lines any more, a great many expensive hard roads everywhere, with very few horses and buggies on them.

Airplanes jet by me. My radio receiver picks up commercials, and educational programs, and I can talk back to my ground crew. Television aerials stud the land. Everything seems to speak of interchange.

The city reaches out into the country, and there are roof gardens of various kinds in the city. I cannot help but note that the state institution below me is a community larger than many of the villages in the middle distance.

I cannot help but think that in the city there are also hospitals, some of them with patients who would certainly have been in the state hospital in other times.

Then in the medical office buildings there are psychiatrists doing psychotherapy—both the sitting and the lying down variety—all quite busy, too. There are medical schools buzzing with talk of total personality; outpatient clinics; psychologists, social workers, nurses, general practitioners clamoring for short-cut psychiatric methods for the treatment of alcoholism and peptic ulcers, and lawmakers deliberating on statutes, and a great deal else besides.

In other words, there is much traffic and I cannot help but wonder how it is being directed, and what study is being given to the way it is directed, so that the people involved in it can get to their proper destinations as safely and as happily as possible.

Conceptualization being my assignment, I shall try to assemble the observational and factual elements necessary for the purpose.

Learning will have to be based on these, and learning must precede teaching. At the end lies implementation. In the process, some organization of data is essential, but only when basic laws are discovered can data be fixed into a permanent pattern.

I have discovered no basic laws, unless you will grant that the gathering of sufficient substantiated facts, and the relation of facts to one another, are important in determining the direction of action. I have, however, adopted certain conclusions as bases for further exploration.

The first is that we do not yet know enough about the nature of mental illnesses to justify us in a great many positive pronouncements as to causation and treatment. We do have some hard-won knowledge. The lessons gained from this, even when they seem obvious, are not

always heeded. We must discover more, and we must be about that business of discovery.

We should not crow too much about our last discovery that seems to us to scintillate. Fools' gold is not gold.

An expedient remedy may not be—usually is not—a good one for general use. We can mislead our strongest allies if we let them think that it is.

It seems to me that we do not teach enough about these matters. They seem too negative, too pessimistic. However, they are honest.

I am merely pleading for open-mindedness, without ill-judged pursuit of false positions.

I would ask you to think of some of the testimony that is given before Congress at times, when appropriations are sought. I think it is necessary that we change our attitudes somewhat if we are to have a solid foundation for what we may build.

We will however, concede that methods which have been developed for the practical management of mental illness at this time provide evidence that can serve as a guide to the future. That is, much of what we have learned up to now really has reason.

ALL THESE THINGS which I have mentioned—need for more knowledge as to the nature of mental illnesses, open-mindedness, the development of empirical knowledge—I regard as necessary steps in the acquisition of more knowledge. I would like to suggest two other steps which would lead toward sound implementation, implementation which has begun in many places.

Let me speak first of the mental hospital as a state institutional community, for the mental hospital is also a community. It was once much more regarded as a special unit than it is now, a community that followed a vogue common in fields other than that of mental illness.

A hundred years ago, communities of various kinds were formed on principles—religious, social, racial and other criteria for identification.

There were Amish communities, Moravian communities, Mormon communities, the New Harmony, and a great many others. The country presented many examples.

The mental hospital community was a very special one. The qualification for admission was insanity. The aim of operation was curability.

The principle held as to causation was physical. The treatment employed was largely moral and isolational. The argument for state investment was economy.

The claims—and with strong medical backing—were of 95 per cent cure with early enough treatment, and we believed all this.

The state hospital community has modified during the years like the other communities. But like most of them, the population has become larger.

In the beginning, many of these mental communities were called asylums. At that time the hospital idea in general was not in the ascendant. The mentally ill were cared for in asylums and retreats. With the development of the hospital idea generally, they became more like hospitals. And today nearly all of them are called hospitals.

They are also communities—not family unit communities, but communities based on an individual citizenship determined by the individual's possession of special illness characteristics. They still remain hospitals, however.

This brings me to a painful subject, that is, their accreditation as hospitals, and the attempt at reconciliation of two seemingly irreconcilable views.

I think most of you know that the Joint Commission on Accreditation of Hospitals offers a free service for the inspection of hospitals. Also, it inspects the mental hospitals on exactly the same basis and terms of examination that it inspects all other hospitals. The fact that the Joint Commission does not even include the services of a psychiatrist at any level seems to make no difference.

Our A.P.A. Central Inspection Board and our own standards in the American Psychiatric Association go about inspection in a quite different way.

Every community deserves a good hospital, good outpatient services, good medical visiting services, and good general living conditions. But the whole community need not be regarded as a hospital because a hospital is located in it.

Accreditation of a general hospital for a city or town is not determined on the basis of the conditions in the total community it serves, but simply upon its own performance as a hospital; and if it has earned accreditation as a hospital, it will get it.

My suggestion is that the Joint Commission on Accreditation of Hospitals might well inspect and approve the actual medical services of that larger community which we call the mental hospital. This is all that the Commission is really entitled to do. For a mental hospital, such as we know it, the Joint Commission type of examination and accreditation is meaningless, unless it is limited to that part of the organization which has to do for its specialized community the same kind of work that a general hospital is supposed to do for the general community.

My second suggested step, with its appended concepts, concerns the mental health services in the community, their kind and nature, their organization and use, with reference to community needs.

IN ORDER TO present my views on this I shall read from a report that I made two years ago at the request of the Texas Medical Society, and comment upon it. This was a further development of a report rendered over thirty years ago for the State of New Mexico. I do not know how fully any of the recommendations have been carried out in either place.

You will find nothing really new in the concept that I shall advance. Its implementation, however, is extremely difficult.

In other words, it is very hard to induce change when a fixed organization is already functioning even though it is functioning inefficiently. This is the quotation:

"It is suggested that a state be regarded as being made up of several population segments. The conformation of these segments will change from time to time and are somewhat predictable on the basis of population and economic studies.

"It will be necessary to start with the present population segments or regions, and to consider what services

are currently available in them and what changes are necessary to effect improvement in each segment, with the intent of bringing the service level in all segments to the same standard of excellence eventually.

"The pattern of the state hospital is a considerably familiar one. The maintenance of adequate treatment service for patients is the chief problem here. It has long been recognized that in hospitals where treatment is given in connection with training and research programs, the service is at a better level than in hospitals where this is not the case. However, opportunities for training and research are commonly at a minimum in state hospitals, which are overcrowded and understaffed. If the community relationships are also poor, the hospital is in a bad state."

Let me explain the implications of this quotation.

The remedy suggested was that, for each state hospital, there be at least one outpost in the general community which the hospital serves. This outpost should be a clinic and hospital of much smaller size than the state hospital itself, providing within its limitations inpatient and outpatient service to the community.

The chief limitation should be size, because a small organization will permit good control of treatments and of training and research activities.

The communication between the state hospital and the community clinic and hospital should be closely maintained. On the other hand, the communication between the community clinic and hospital and the local community and all of its community agencies and resources, should be of the strongest.

Between the state hospital and the community outpost there should be free interchange of treatment service and the training and research programs, and even some rotation of key personnel, and most important of all, a unified supervision, under a single authority, in the person of a regional director or general superintendent of both facilities.

The whole unit—as with all similar units in every place in the state—should operate under the direction of a state director with his subordinate chief in charge of medical services, training and research, as is the usual plan.

THE COMMUNITY CLINIC and hospital deserves a few words of description. It should resemble the psychiatric institutes or departments conducted by medical colleges. Medical education at the undergraduate and specialist levels cannot be conducted adequately unless there are such departments or institutes.

However, the emphasis in these institutes is more on teaching and research, though treatment of a high order of excellence can be obtained in them. A considerable extension of their treatment service greatly impairs the control of teaching and research programs. The emphasis in a state-conducted community clinic and hospital should be on service to the community. The purpose of inclusion of training and research is only to improve service so that the service objective will not be minimized in importance.

The supervision of the community clinic should be under the same administration that is responsible for the state hospital. Invitation for participation should be extended to all of the teaching agencies and other institutions, because this will reinforce the service program.

It is preferable that sole dependence be not placed on the contributions of agencies other than the ones under the supervision of whatever board is responsible for the state hospital.

UNDOUBTEDLY, questions will arise as to the facilities and staffing of the community clinic and hospital. It should be located where people can get to it easily. It should have a full-time outpatient clinic and inpatient service of approximately 50 beds. It will require inpatient chiefs of service when in full operation.

The community clinic and hospital should be heavily dependent on attending and consultant services, possibly on a fee basis, of psychiatrists and other physicians practicing in the community, for the idea is to reinforce every community connection.

For the training and research activities, a clinical director should be provided. The service division should have the usual service personnel. The training division should supervise all types and levels of personnel training. Assistance in this task will be required for psychiatry, psychology, social work and nursing.

In the beginning, the director and assistants will probably be sufficient in number to supervise the beginning of research activities. The local institutions can contribute to this.

The chief modification as far as the state hospital part of the unit is concerned, will be one of organizational lines of authority. While the state hospital, being a large institution, will need a separate superintendent, this is possibly not the case in a community clinic and hospital where a chief of service can function adequately.

Some regional director over both institutions should be in the scene. His office may be in either place.

Now, much more might be said about organization and lines of authority. There are evidences that something resembling this scheme is already in operation in some places. But in no state in this country is it in operation on a plan which permits a continuous and ready flow toward the state hospital and back from the state hospital, under the control, not of the local community, not chiefly of the state hospital itself, but located between the two, and effectively supervising the treatment and rehabilitation facilities of both.

Furthermore, this agency should serve a very valuable function in providing inspection services and accreditation services of its own for the local community private services.

Well, this is the best I have been able to do with the conceptualization and the implementation. You will have to search through the fabric of what I have said to find the philosophical problems of teaching and training. That is as it should be.

In the whole field of service to the weak and the sick, the fabric that does not fall to pieces is interwoven with many threads—loving acceptance of the task of giving aid and succor, together with the other threads of learning, of teaching, of research. Only if it has enough of all these threads will it serve the needs of humanity.

NEW CONCEPTS OF PERSONNEL

Needs Are Changing

New concepts of the environmental and therapeutic needs of patients call for new kinds of employees. There should also be revaluation of duties and possibly redistribution of existing personnel.

Discussion Leader: Dr. HOWARD P. ROME

THE PRESIDENTIAL ADDRESS delivered at the American Psychiatric Association's annual meeting in May, 1958, by Dr. Harry Solomon, has stirred comment throughout the country. Almost everyone concerned with mental hospital administration is familiar with the speech, which has since been published in the American Journal of Psychiatry (July 1958, Vol. 115, No. 1, pp. 1-9). In his discussion of personnel needs, Dr. Howard P. Rome referred to Dr. Solomon's speech and commented wryly that it points up a need for a change of the baby and the bath water. But certainly, he said, the speech made it explicit that Dr. Solomon saw the conventional organizational structure of the conventional mental hospital in 114 years of effort as having become antiquated, outmoded, and obsolete.

We are all agreed, Dr. Rome continued, that there is a need for a place for the mentally ill and certain kinds of people to look after them. The question is, how can we do it most effectively and with what?

IT HAS been shown that an upgrading of patients can be achieved by social manipulation. It has been shown that the physical structure of a hospital, for example, determines not only the behavior of the patients but the behavior of the staff as well. And to an even greater degree, attitudes and communication among staff members affect the patients.

When the expectation is that a patient will spend a short period of time in a hospital, there has to be social and community orientation on the part of the staff. In part, this is demonstrated by the creation of new jobs and new functions. Included are such developments as industrial counseling; greater liberality in prescribing privileges; employment of persons who are convinced that restraint implies neglect; development of on-the-job training programs; establishment of outpatient clinics—to name only a few.

Obviously, the more kinds of tasks taken on by those in hospitals, the more kinds of persons are needed to do them. Psychiatry has jumped over the walls of Dr. Solomon's ancient hospitals. More than a quarter of a million annual admissions to psychiatric units in general hospitals are a testament to this.

THERE is a growing tendency to think of functions first, and structure subsequently. So the old semi-permeable membrane which encased the mental hospital has been removed. Where the institutional functions stop and community functions begin is a real question. Who has the responsibility, for example, for staffing follow-up clinics? How far afield does the hospital's social worker go? Because if he goes too far, there is a need for more workers to do the many jobs that he leaves behind.

If there is better staff communication, there has to be more time taken for staff meetings. In turn, more staff is needed to do what the staff group concludes has to be done.

When a drug regimen is successful, a social orientation on the part of the staff is obligatory. More and different kinds of nurses and aides are required to help patients get out of the hospital than are needed to keep them in.

Shortage of personnel is not a new topic for discussion. It is a perennial topic and the magnitude of need is well understood by all. Dr. Rome characterized further discussion of it as pseudo-masochistic, since it means little more than pouring salt into already painful wounds. What is new is a need to take a fresh look at the job to be done, how personnel we now have can be adapted to doing it, and what new skills can be recruited.

The pendulum has swung too far, one doctor felt, in the uproar that has been raised about hospitals. In such discussions, the hospital is conceived of as a necessary evil. So extreme have attacks on the hospital become that it is actually presented as bad for the patient. Such attitudes have done great harm to the impetus, to the motivation of a hospital staff to do its job; to help

Participants: *Dr. Nathan Beckenstein, N.Y.; Dr. Wm. W. Bourke, Ill.; Dr. Willard C. Brinegar, Iowa; Dr. Anthony K. Busch, Mo.; Dr. J. O. Cromwell, Iowa; Dr. Addison M. Duval, D.C.; Dr. Ray H. Hayes, Ky.; Mr. James C. Hodges, Mich.; Dr. Thaddeus P. Krush, Neb.; Dr. J. Mackay, Ont., Canada; Dr. David P. Morton, Ind.; Dr. Arnold A. Schillinger, N.Y.; Dr. Benjamin Simon, Mass.; Dr. M. A. Tarumianz, Del.; Father E. J. Zizka, La.*

people deal with their emotional problems so they may return to the community in good time, whatever that time may be. It has gotten to the point where a patient is expected to be hospitalized on a sort of moving belt—in and out.

We should conceive of the hospital as a therapeutic community. It is a living situation where a patient can be helped to reestablish harmonious ways of living with himself and others. This he must do in a hospital because he needs a tolerant and understanding attitude.

Scoring the current controversy the speaker concluded: "The attack on the hospital sounds as if hospitals were performing an evil. We know that no hospital can perform the job it should be doing; many perform poorly for various reasons. But if we try to solve the problem by saying they must not have the job, or that it is bad for the patient, we have created an atmosphere that we will never get rid of. The hospital is made obsolete by our attitude toward it, which is conveyed to everyone who is working there."

"The boundary of the hospital does not end with the walls," was a view voiced. "It ends, rather, with the area in which it is supposed to serve."

Imaginative use of personnel is called for. This means both familiar personnel, such as the psychiatric nurse, moving into community service; and not-so-traditional people, such as the teacher, coming into the mental hospital. A further extension is the establishment of cooperative working arrangements with community agencies which the patient may encounter on his return to the community. These would include such facilities as employment agencies, training institutions, social welfare groups, etc.

In the opinion of some participants the new emphasis on returning the patient to the community is a cart before the horse proposition. There are not yet enough of the proper kinds of community facilities to make this feasible. Such facilities must first be provided, which of course means staffed, and there are not enough psychiatrists, psychologists, and social workers in the community, nor are there funds available for them.

"Unfortunately the community is not well prepared to shoulder its responsibility to take care of patients who are well enough to be treated at home," Dr. Tarumianz said. "Our job as commissioners and superintendents and staff members is not to rush and send all our patients to the community without proper facilities to guide them, direct them, and help them become rehabilitated to community life. I think that is one of the great mistakes we are making at this moment."

The number of patients returning home from mental hospitals has already increased greatly since 1945 from the pattern of the years before that. Before 1945, half the people subtracted from the rolls were deceased, a doctor said. Now twelve people leave a mental hospital to return home for every one who dies there. Personnel is already shifting because of the story these statistics tell.

The suggestion was made that there are community facilities which can be used for patient support, but they should be used by the patient while still hospitalized as transitional experience. Such things as aptitude testing and rehabilitation services offered by community agencies might be stepping stones. First tentative steps might include use of community recreation facilities. Of course, the hospital itself should be considered a community facility and there should be no artificial barriers between the two.

An Indiana superintendent said his hospital has initiated a plan to have two chaplains come to the hospital for three months for part-time orientation, and expects to expand the number to four. This will give them insight into mental illness which they can use in their own home church in helping former patients.

In the drive to enlist the skills of professional workers in the surrounding town, new emphasis is being put on the importance of including the general medical practitioner. Short term courses can be planned to equip them to take over many types of care. For example, geriatric patients may constitute from 30 to 60 per cent of a hospital's case load; G.P.'s have been found of valuable assistance in a program to get them well and discharged.

The American Psychiatric Association's standards for hospital personnel need revision, a hospital psychiatrist said. These standards, setting forth the number of physicians, social workers, psychologists and other personnel in hospitals, have served as a measuring stick. The contention was they do not take recent developments into account. For example, at present a large contingent of personnel is needed to train other personnel. A hospital may have five social workers. If a training program develops as the result of community participation, one of these social workers must be subtracted from the total on the job.

Agreeing that the standards are already obsolete, it was pointed out that the original idea was that they should be subject to continuing revisions. They were intended as temporary guide lines, a start. Now there is a need to develop new methods, new programs, perhaps assign personnel differently than when those standards were written. The advent of the tranquilizing drugs, for instance, requires a look at what nurses are doing. Are they being used just to "push pills?" Are they really doing psychiatric nursing?

These standards are not the only ones which should be continually subjected to revaluation, Dr. Rome said. The A.P.A. staff carries out many studies of this nature. Examples are the studies of the use of architectural space and hospital services that can be provided by volunteer workers.

A superintendent declared that the most important person in a psychiatric hospital is a psychiatrist, and maintained, in the face of some argument, that he could hire all the psychiatrists he needed provided he had sufficient money. His statement was attacked on the grounds that there are only about ten thousand psychiatrists in the country, most of whom are not willing to do institutional work on a full-time basis. The only answer is to produce more psychiatrists, and

for that matter, more physicians of all kinds. Too many young people have no idea what to do to become a physician, and if anybody should be censured for the current shortage of general physicians and psychiatrists, it is the institutions of higher learning. Some grass roots education is badly needed.

Another method of handling the shortage of psychiatrists is to make better use of the physicians we already have—not only psychiatrists, but general practitioners too, some of whom might well give us much assistance in the care of the chronically ill and especially the geriatric cases. Money alone will not solve the shortage problem. If we proceed on that basis, we shall simply be stealing from one another and no national remedy will be found.

A layman concluded the discussion by saying that since it seems that we shall never have enough people —not only psychiatrists, but all the other personnel as well, it behooves us to put our minds to the job of utilizing all the people we have in the best possible manner. We should examine their goals, and assign them the jobs they can do best. Put psychiatrists to work doing psychiatry and being the leaders of the hospital teams.

Organizing to Meet New Needs

To run a truly therapeutic hospital, we must meet the needs of employees as well as patients. It is the responsibility of institutional management to recognize and meet the needs of today's higher type of employee.

Discussion Leader: Dr. HAROLD L. McPHEETERS

THE EXISTENCE of new personnel needs was assumed in this group without discussion; participants concerned themselves mainly with hospitals' organizational pattern. Some felt the philosophy on which the organizational structure would be set should be the starting point, that philosophy being nothing more abstract than how the dollars and cents devoted to patient care can best be spent.

Discussion Chairman Harold L. McPheeters, M.D., outlined a plan for reorganizing a mental hospital's table of organization. He saw such reorganization as inevitable in the trend away from custodial care to active treatment programs. Reorganization follows in the wake of the new philosophy.

"In the days when the emphasis was on giving custodial care for a patient at eighty-nine cents a day, the emphasis was obviously not on treatment," he said. "If you were going to operate your hospital on eighty-nine cents per person per day, you would have to do everything you could to save money. If it was a question of spending money to spray the bean crop, or hiring a psychiatrist, it was more economical to spray the bean crop, and that is where the money went.

"I think a lot of this organizational structure and attitude has been carried forward. Today we have a new philosophy of treatment in our mental hospitals, and I think our organizational plan must change, or the therapeutic personnel who are expected to carry on the new treatment program will be dissatisfied. If they become dissatisfied, they will leave.

"Much of our problem lies in the kind of job we give people, rather than the money we pay them. Top level professional people want their role understood by top management. They want to be recognized by status, not just pay. They want to be used for therapy, not for administration, not to give custodial care, not just to keep patients busy.

"Top level administration—the state commissioner, the hospital superintendent—must have this philosophy of treatment," he said. "Then it must show up in organizational patterns, in budget patterns, in administrative and clinical standards."

DR. MCPHEETERS advocated the formulation of organizational charts, and strongly recommended that written descriptions of the qualifications, the roles and the relationships of each position on the organizational chart be duplicated and made available to other administrators. He pointed out that his own plan is now available in booklet form. When he first began to delve into the subject he wrote for all the information available from the A.P.A. Mental Hospital Service loan library and also corresponded with various hospitals. He discovered that only four or five state systems could provide written reference material of this sort.

Dr. McPheeters believes that a split between administrative authority and clinical authority is essential for any large hospital or hospital system. He said such a split has long been recognized in the general hospital,

Participants: *Dr. Alfred K. Baur, Mo.; Dr. Nathan Beckenstein, N.Y.; Dr. John J. Blasko, D.C.; Dr. J. O. Cromwell, Iowa; Dr. Charles W. Dunn, Mich.; Dr. B. P. Grimes, Minn.; Dr. Walter J. Fisher, N.S., Canada; Dr. Granville L. Jones, Ark.; Dr. D. G. McKerracher, Sask., Canada; Dr. Walter Rapaport, Calif.; Dr. Benjamin Simon, Mass.; Dr. Wm. S. Simpson, Kansas; Dr. Harry C. Solomon, Mass.; Dr. M. A. Tarumianz, Del.*

and acceptance of this approach in the mental hospital is the order of the day.

One can understand how present attitudes grew up. First of all, the medical staff in the mental hospital is in full time attendance. It is very easy, when the doctor is right there, to fall into the habit of going to him with administrative as well as clinical problems.

Also, as administrative positions have developed they have often been filled by business administrators, who are not necessarily trained hospital administrators. In many cases the jobs are held by old-time stewards, usually political appointees, whose entire emphasis is on business and economy. It is entirely understandable that clinical personnel might be highly resentful of any suggestion that they should report to such a person in the professional areas of their work.

Under one such arrangement, Dr. McPheeters found a hospital's clinical director, a trained psychiatrist, was spending seventy to seventy-five per cent of his time in administrative duties. As a psychiatrist, he resented this unsuitable use of his time.

Under the reorganization plan, a trained lay hospital administrator has been employed. The psychiatrist can now devote his full time to his work as clinical director. Working with clinical department heads, he is busy developing and supervising programs for open wards, follow-up units, screening units, industrial therapy programs, and therapeutic programs to reduce the use of restraint and seclusion.

The clinical director also works closely with the hospital administrator, especially when they are going into a new program or adjusting an old one. This keeps the administrator informed about what personnel and material needs are anticipated, for it will be his job to fill these.

All department heads—nursing, social work, psychology, industrial therapy, etc.—report for administrative direction to the administrator and for clinical direction to the clinical director.

An organized personnel section takes over the task of recruitment and orientation of new employees to hospital policies. The new worker is given data on vacation leave, sick leave, policies relating to job rights, and information about the hospital's physical facilities. Technical information about social security, welfare programs, credit union, and recreation programs are included. Further, the personnel section conducts orientation courses for people not specifically assigned to therapy programs. These courses are designed to prepare them to work with patients, since patients work in industrial assignments in all areas of the hospital.

Dr. McPheeters emphasized that although all of these services are provided by the personnel office, the prerogative of "hiring and firing" remains with the department head concerned.

As to the question of whether the many adjunctive services such as rehabilitation, industrial therapy, volunteers, and chaplains, should be put in one over-all category with a director over all of them, Dr. McPheeters held out for separate department status for each. Further, he recommended that this status carry with it a separate budget, however small, so that no one would be forced to beg for funds to meet small needs.

"I grant you that if you give each of these departmental status, it spoils your administrative dictum that your span of control must be short, the number of personnel reporting to you small," he said. "But otherwise what happens is this: the occupational therapist, who is a professional person with a degree, says, 'Here I am, second to a director who is on the same level with the director of nursing. And this is where I am hung on the ladder.'

"And, in such a hierarchy, you find the nursing department head saying, 'After all, occupational therapy is down the line from me in the organizational structure. Today is bath day. The patients will have to take baths, and not go to occupational therapy.'"

Chairman McPheeters saw a need for a coordination of these various services to prevent such squabbles, but felt the solution to be a coordinating committee formed from representatives of each. This would avoid such possible conflicts as a ward party planned for the same time as a film scheduled by the recreation department.

The emergence of the importance of industrial therapy is another intra-hospital problem which has created questions of conflict of authority, particularly with occupational therapists. If there is an industrial therapist and his responsibilities are clearly outlined, the whole program of industrial therapy is then divorced from occupational therapy and the occupational therapist is free to carry out the professional tasks for which he was trained. The industrial therapist should be responsible for the selection and supervision of work assignments based on patients' emotional needs, intellectual limits, and physical abilities. He should also be involved in finding ways to give recognition and compensation, if any, to patients who work, arranging "privileges" for working patients, and handling any other administrative details necessary to make his program function smoothly within the hospital's routine. Industrial therapy is primarily designed to teach patients habits of regularity, help them adapt to supervision, give them experience in working with fellow employees, and require them to keep some sort of regular production schedule—in short, to help them become accustomed to the sort of work habits they will need to hold a job.

Second in command to the clinical director is a chief of medical staff, a psychiatrist, who reports directly on clinical matters. He has a similar direct contact with the hospital administrator on administrative matters and holds the some relationship to the physicians on his staff as a chief nurse does to nurses. Hospitals are operated on a unit system, the doctor in charge of each unit being responsible for its total treatment program.

Use of a unit system is, indeed, a drastic change from procedures in effect before reorganization. Formerly decisions on diagnosis, therapy, and discharge of a patient were made by a panel of doctors, possibly only one of whom was personally concerned with the patient's care. With both authority and responsibility, physicians

in charge of units have been liberated to put their medical knowledge into practice.

Dr. William S. Simpson, Topeka, described how the state hospital there is organized on a unit system so that a 1300-bed hospital takes care of four sub-divisions of that number of patients.

Of these four units, two are for women and two are for men. The essential feature is that all kinds of patients are admitted to both units. Patients are simply sorted by sex, not diagnosis. A unit may contain geriatric patients, acutely ill patients, infirm patients, and those returning from parole, to cite a few. Each section is headed by a section chief, who has full responsibility for it. Advantages are that the patient is always under the treatment of the same therapeutic team. The staff is kept on its toes to deal with all types of illness, not becoming isolated in a sub-specialty of treatment. This also makes recruitment easier, since no one draws assignments limited to distasteful details. Dr. Simon commented that this design was essentially the same as that used in large army psychiatric centers in World War II.

Reorganization of mental hospitals should take its cue from the lessons taught by general hospitals, Dr. Tarumianz reiterated. (He spoke out at other sessions on this theme.) Essentially this demands a different treatment approach for the acutely ill patient and the sub-acutely ill patient.

"It behooves us to demand that we give our patients the identical intensive treatment that the patients in general hospitals receive at a cost of fifteen or twenty dollars a day," Dr. Tarumianz said.

"Taxpayers can afford to spend fifteen or twenty dollars if only twenty per cent of patients now in state hospitals receive such treatment. But they will be bankrupt in no time if you demand they spend for 750,000 people the same amount as is spent for the acutely ill.

"My plea is this: The A.P.A. can start to work toward the kind of separation which general hospitals have already accomplished only by a separation of the acutely ill from the chronically ill."

Dr. Harry Solomon reminded the group that large institutions carry a very great number of individuals who are not getting anything which, in the ordinary parlance of medicine, could be called treatment. Perhaps two or three thousand patients are cared for by a staff of ten physicians or less. This calls for facing the fact that if any intensive treatment is to be given, some hard-boiled decisions must be made in terms of the chronic, long-term patients for whom we are doing very little. So he felt reorganization should be "not in regard to the details and the organizational charts, but the general philosophy of what the hospital is to stand for."

A California doctor agreed that the general practitioner and specialists other than psychiatrists, given some understanding of the problem, could perhaps take care of 40, 50, or 60 per cent of the patients outside the hospital.

But he reacted strongly to what he considered an implication that public mental hospitals should "lock their doors to what could be considered hopeless and chronic patients, without any real investigation of whether they are in fact hopeless or chronic. Who is to decide?"

Dr. Tarumianz felt this comment implied that his suggestion, and those of Dr. Solomon, had been misconstrued. He did not recommend that words like "incurable" be used. The simple political fact is the states cannot afford to pay twenty dollars a day for treatment of the chronically ill. But sort out the chronically ill and care for them in county homes, private nursing homes, or some other system providing adequate supervision, and you will be able to treat and discharge the patients who *can* be reached by psychiatric techniques. This would bring about only the dichotomy of patient classification—acute and sub-acute—enforced by general hospitals for fifty years.

Neither is it suggested that the long-term patient be written off as incurable. Such patients would still be carried in regimes where all known medical knowledge would be applied to each case, but it would be a different type of medical care than that practiced in the mental hospital giving intensive psychiatric treatment.

CANADA has already taken some steps in this direction, it was pointed out. In Nova Scotia, so-called chronic cases are transferred to what are designated as county homes. These homes are surveyed regularly by the mental hospital staff to ascertain if patients there can be discharged to their own homes or if their condition has changed in any way that would now make psychiatric treatment effective. In the latter case, they are transferred back to the mental hospital.

The Province of Saskatchewan has a plan for 300-bed hospitals for every population unit of 60,000 people. These would be for treatment of acute cases, with the patient directed homeward—if not to his own home, then to a foster home or supervised boarding home. The hospitals "will not be cesspools of chronic patients."

Dr. Beckenstein suggested pilot projects be established to demonstrate the feasibility of care for chronic and acute cases. This technique proved effective in establishing intensive treatment units in New York State. Efficacy was first demonstrated in four hospitals, and then funds were secured for such units in all institutions in the state.

Dr. Granville Jones summed up the discussion by pointing out that, "we are operating in an increasingly tight manpower situation, and I think we have to reexamine and revaluate the functions we assign to the various personnel that we can get our hands on . . . we should never use a highly trained person to do anything that a lesser person can do. . . . We must learn to use our people in a different way than we would like to use them. The trend today is toward automation, delegation and mass production techniques, and I think we can apply this to psychiatry without too much difficulty. After all, the human organism does have an inherent capacity for getting well if we as doctors and hospital administrators do not create situations which prevent the patient from getting well. We ought to be engaged in creating optimum conditions so that the person can get well!"

TRAINING OF WARD PERSONNEL

We depend to a large extent on ward personnel to help create the therapeutic atmosphere we require. Because their function is no longer largely custodial, they must be trained to take a more active part in bringing about improved treatment of patients.

Discussion Leaders: Miss TIRZAH M. MORGAN, R.N.
Miss MARYHA GIBSON

ALL OF THE so-called revolutionary new approaches to treatment in mental hospitals—remotivation, resocialization, therapeutic use of self—require that ward personnel become more potent forces in helping patients get well. New drugs, making the patient more accessible to treatment, have been largely responsible for the present emergence of this school of thought, though some see it as an evolutionary development at least ten years old.

As a nurse put it, though, you can't just say, "Hocus-pocus. Yesterday you were custodial personnel, today you have a therapeutic function."

Just how therapeutic can an aide get? Theoretical discussions can elevate this assignment to something on a professional par with the nurse or even the psychiatrist. They can also evoke some dour comments about what the aide-in-being really does.

Many professional groups are making exploratory efforts to devise training that will enhance the usefulness of the ward aide, and progress was reported in several areas. Provocative questions still being raised are: Is this training just a device to improve personnel status or is it truly training to improve the care of patients? Will these trained aides simply move into administrative echelons away from patient care and so give rise to the complaint, "No one is left on the ward," just as advanced training for nurses brought forth the comment, "No one is left at the bedside"?

One skeptic said: "I have had attendants complain to me about this and say, 'Look, you are paying us $162 a month. The old idea was that you sat on a rocking chair, and as long as you kept everybody quiet and had no trouble, you went home at the end of your shift. You took care of the ward, kept it clean, ran a nice clean institution. And that was the basic job.'

"But now all of a sudden we want each one of them to be an individual therapist. Whom are we going to get to do what needs to be done? Who is going to take patients to X-ray, to the lavatory? Who is going to see that the bathrooms are clean? Who is going to perform the many other functions the attendant now performs?

"I question how far we can go to make people at the usual educational level of attendants experts in the nuances and finesse of personality dynamics."

IN A GROUP representing as many varied hospital organizations as this one—people from private hospitals, large Federal installations, the small and the large state hospital—explosive comments were bound to be offered on the issue. One thing was clear: the prototype of the aide to be trained was not the same in everyone's mind. One speaker described an aide as a fellow whose idea of getting cooperation was to call to a patient, "Hey, Joe, come up here and clean the bathroom."

A discussion leader, Martha Gibson, herself an aide, commented that effective aide training would teach how much could be accomplished in inter-personal relationships while the aide is cleaning the bathroom with the patient, while he is taking the patient to X-ray, while they are doing these and other things together. You don't call the patient in and say, "Clean the bathroom." You don't say to the patient, "Clean the windows." You do these things with the patient.

An ambitious plan for training the ward psychiatric aide was presented by the co-chairman of the topic, Tirzah M. Morgan, a nurse. First, there must be a careful screening of personnel accepted for training. The functions they will perform when trained must be defined. Seeing it as impossible to completely separate the other duties of the aide from nursing duties, Miss Morgan heartily recommended training in nursing skills.

"We would hope to develop an understanding that caring for the patient's physical needs is an essential aspect of psychiatric nursing care, and that the physical and psychological aspects of nursing care are interrelated. The aide must be taught to develop skills which will enable him to make and communicate to other staff mem-

Participants: *Dr. Freeman H. Adams, Calif.; Dr. Alfred K. Baur, Mo.; Dr. Nathan Beckenstein, N.Y.; Helen R. Edgar, R.N., Pa.; Dr. George A. Elliott, Mass.; Richard Elwell, R.N., D.C.; Dr. Robert S. Garber, N.J.; Mrs. Helen Graves, Wash.; Alice Herzig, R.N., Tex.; Dr. John Houck, Conn.; Dr. Granville L. Jones, Ark.; May M. Kennedy, R.N., N.J.; Josephine I. Lamb, R.N., Tex.; Miss Talmage H. Lewis, Ky.; Helen B. Linehan, R.N., Mich; Dr. Harold L. McPheeters, Ky.; Dr. J. M. Mosier, Ind.; Martina Nelson, R.N., Mo.; Dr. Thelma V. Owen, W.Va.; Mr. Vernay N. Reindollar, Ind.; Dr. G. Lee Sandritter, Wash.; Mrs. Anna T. Scruggs, Okla.; Dr. J. B. Smith, Alaska; Dr. George S. Stevenson, N.Y.; Ethel Strueben, R.N., N.Y.; Dr. M. A. Tarumianz, Del.; Mr. M. A. Thompson, Ind.*

bers accurate observations on patients' behavior.

Other recommendations encompassed academic familiarity with psychology of the individual, physiological aspects of nursing, and specific problems of administration on a psychiatric ward. Classroom instruction would be supplemented by practice in clinical areas where academic theories would be practiced by the student under the supervision of clinical personnel. The total training program would be under the leadership of professional nurses but Miss Morgan expressed hope that before too long aides will be able to carry at least part of the training.

Mrs. Gibson lit a time fuse when she said in her speech: "Due to the shortage of nurses, the aide is generally expected to give medications. It is very important that he be familiar with the preparation, administration, and the expected effects as well as the toxic effects of the drugs commonly used in the mental hospitals."

This fuse exploded as soon as Dr. Tarumianz was able to get the floor. "I wish to state that you are on very dangerous ground when you make a statement that psychiatric aides may administer drugs . . . One of the things that the American Medical Association is demanding in the inspection of hospitals is that under no circumstances will anyone who is not a trained, registered, licensed nurse, administer drugs . . . One of their objectives is to have the (mental) hospitals comply with the same principles as the general hospital, where no one can administer drugs, regardless of how well they are trained in psychiatric work, unless they are registered, licensed nurses." (See Hospital Accreditation References, A.H.A., p. 131).

The apparent implication that mental and general hospitals must operate in the same way did not mirror the views of everyone present. Legal or not, medically approved or not, in many hospitals aides are handing out pills to patients. One defense is that the patients are given medicine to take without supervision when they go home. Isn't the supervision they get on the ward much better than this?

One doctor from an institution for epileptics said aides there not only give oral medication but administer intramuscular injections, such as penicillin and insulin. He saw no difference in this procedure and that of parents giving medicine to their children. Dr. Tarumianz rejoined that this was contrary to all the principles of medicine, a violation of the law pertaining to the practice of medicine. He saw it as a serious matter, one which might be a matter of life and death.

This was not the only time in the course of the Institute that candor called forth testimony that since the advent of tranquilizers, dispensing of medication by personnel other than nurses has become widespread. A common justification is that there are not enough nurses to do more than supervise.

Miss Morgan questioned whether all aspects of a mental hospital should be looked at in the same light as a general hospital. Wasn't the parallel more true in some types of care than others, and wasn't the mental hospital making a mistake in not training different staff members for care of different types of patients? Does the aide or nurse need the same kind of training to work in the acute area as in the self-care area? Hadn't lack of analyzing this question led to the lump designation of custodial care? She cited the general hospital's recovery room, which is staffed by specially trained nurses, and suggested similar specialization in the care of psychiatric patients.

Mrs. Gibson was asked how long she believed a program such as she outlined would require. She replied the plan would call for a year's training, primarily in the teaching area on the clinical wards. The number of students able to be accommodated would depend on the number of clinical supervisors available but not more than four or five students should be working in a clinical area at any one time. Classroom attendance might be larger, though perhaps ten, twelve, or fifteen students would be the ideal number to insure free discussions.

"Remotivation," a word put into the glossary of psychiatric aides through the recent efforts of the Smith Kline and French Foundation's joint project with the American Psychiatric Association, is arousing increasing interest among administrators. Essentially this is a new technique of training ward personnel to stir patients to communicate their thoughts and feelings freely. A movie has been produced showing how simple subjects lend themselves to situations which draw patients out, and a team of leaders is available to present the training program at hospitals. In October, this team had visited nine states and presented the idea to 179 ward workers. Thirty-nine states have asked to participate, and will have been visited by the team by May. Another team is in training to meet the burgeoning requests for this help. Comments from hospitals already visited are enthusiastic.

Dr. Granville Jones reported that a round table on training of psychiatric aides produced some stimulating ideas at the 1957 Annual Meeting of the A.P.A. For one thing, a beginning was made on establishing guide lines of what a standard training curriculum should encompass. As thinking on this is shared and common agreement reached, the A.P.A.'s Committee on Psychiatric Nursing hopes to present a plan acceptable to all. One thing this would mean is that reciprocity would be possible between states since, for instance, an aide trained in one state would meet standards in another.

Actually a curriculum of this sort already exists. A working committee from the National League for Nursing issued a publication on the subject a few years ago. However, realists of that time were appalled at it, feeling its recommendations were grandiose. In the present era, the trend is to think more and more in terms of the specialized training for ward personnel that this report

READERS' FORUM

In the January issue of Mental Hospitals under the Readers' Forum Dr. Lucy D. Ozarin was erroneously given the title of "Director of the H.E.W. Regional Office, Kansas City, Mo." Dr. Ozarin has requested us to correct this error. Her present title is, of course, Chief of the Mental Health Section, U.S.P.H.S. Regional Office, D.H.E.W., Region VI, Kansas City. Our apologies to Dr. Ozarin.

recommends. Dr. Jones suggested taking a second look at this document.

A pilot project to train teachers of psychiatric aides is now being conducted in Arkansas, North Carolina, South Carolina, and Tennessee by a combined committee of the A.P.A. and the National League for Nursing.* Seminars are held for nurses from state hospitals, private hospitals, Veterans Administration hospitals, and university hospitals. The course content stresses basic principles of psychiatric nursing—for many nurses have not had advanced work in this specialty—and techniques of teaching. It is intended to equip nurses to teach aides to use new skills in relating to patients. Ten days of intensive training are given and regional and local committees, in which the psychiatric aides participate, are formed to evaluate and follow up on the project. Comments from nurses and aides indicate they feel this effort has been very useful.

Miss Ethel Strueben of the American Nursing Association said that in view of the comments about general hospitals and mental hospitals, a recent review of nursing functions might be of interest. Nurses surveying the psychiatric setting came up with the consensus that basically, all functions of the nurse are the same whether in the general hospital or the psychiatric hospital.

A psychiatric nursing specialist from the Veterans Administration, Mr. Richard Elwell, made a plea for in-service, ongoing training for the professional nurse. He feels such training has been conspicuously lacking. Speaking of the increased emphasis on specialized training for ward personnel, he said the Veterans Administration is releasing a new classification standard for non-supervisory aides, nursing assistants as they are called, which will raise their starting salary to the level of the starting salary for the professional nurse.

Several individual efforts of hospitals and state systems to encourage training were cited. One psychiatrist suggested that constant guidance from staff psychiatrists will always be necessary lest methods taught aides become a ritual in themselves. He stressed the importance of continuing staff sessions between doctor and aides to give help as problems develop and steer aides away from the pitfalls of "interpretation." One hospital established a week's training program for all personnel by the expedient of having one-fifth of the staff go to the course one day during the week. It was hard to convince some department heads they could function one day with four-fifths of their regular personnel, but they found it could be done. New Jersey, spurred by the Mental Health Association, selected five psychiatric aides three years ago and paid full salary for half-time work to enable the aides to take a two-year training course at a school of nursing leading to an R.N. degree.

Actually what all this training boils down to, a seasoned hospital man said, is teaching attendants how to encourage patients to come in contact with reality. He added a hilarious note to the controversy on methods by telling of an incident which occurred shortly after the open door policy was put into effect at his hospital.

"We had one patient who had been in the hospital for many years. When we first unlocked the ward he went out of the hospital. Later that night we got a telephone call from him. 'Doc,' he said, 'come and get me.'

"He decided, he told us when he got back, to walk away from the hospital because he had saved five dollars. He thought he would go down town and have a good time. He went down town. He said, 'Doc, I went into the subway. Gee, it's a fifteen-cent fare. When I was outside it was a nickel.' He decided that prices had gone up considerably. He went to the Borough Hall section of Brooklyn, and there he went in to see a show, but it was a dollar sixty-five. 'It used to be thirty cents,' he said. 'There again,' he continued, 'I figured prices had gone up. But when I got out of the show I went to a restaurant to have a bite to eat. But, gee, a hot pastrami sandwich cost eighty cents. And coffee is ten cents. A piece of pie is a quarter. Doc, I decided you were right. I shouldn't try to go out in the community until I am ready and know something about it. Then I went to call you and tell you this, and it cost a dime instead of a nickel!"

Dr. John H. Houck summed it up this way:

"It seems to me that what many of us have tried to say in different ways is essentially the same thing. We are aiming to achieve with psychiatric aides as much as we can to help patients.

"It is important, I think, that we should not forget this in our preoccupation with techniques. The truth is that the majority of patients in our mental institutions do not require intensive psychotherapy. They do not require the services of sociologists, of psychologists, of psychiatrists nearly so much as they require warm, genuine interest and attention from someone who thinks it is worthwhile to give them this kind of interest and attention.

"I think sometimes we take attendants who are anxious to do this kind of thing and, in our efforts to help them function well, we try to make them something they are not, something they really do not want to be: psychotherapists.

"You don't have to understand very much about psychodynamics to be interested in somebody. You don't have to know very much about the psychiatric implications of illness to care about the way a patient looks, or make sure he has a toothbrush with which to brush his teeth.

"If our aides are to function at their best in this kind of role, it seems to me important that we should train them, certainly, but also that we should encourage them to function within this milieu as well as they can, to be warm human beings. And, incidentally, to have ideas of their own.

"Sometimes people get into our mental hospital structure and they learn so quickly all the things you are not allowed to do and all the things which are impossible to do that they lose their individuality, their initiative, and sometimes their interest. It is true that we need organization. It is true that we need as much training as we can give people. But we must not lose sight of the fact that we need people talking to people as much as we need anything else."

* Mental Hospitals, *Vol. 9, No. 6. June 1958, p. 29.*

Full Utilization of Ancillary Personnel

The patient's world is no longer limited to the ward. It is therefore mandatory that full utilization be made of skills of all ancillary therapists.

Discussion Leaders: **DR. DAVID W. HARRIS**
MR. DONALD C. PRITCHARD

NOBODY WANTS to be considered ancillary. The word has connotations of servility to many people. Psychologists, social workers, and nurses on the mental hospital team were quick to show their pique at a discussion of a topic which gave them such a designation. Other personnel, too, are showing on increasing tendency to form special groups, and this specialization raises issues of prestige. The concept of the therapy team has become such a fetish that no one is willing to be considered non-essential on it. This feeling of essentiality precludes acceptance of a designation of "ancillary." It raises the spector of autocracy.

A marathon debate on the use of the word was avoided by a psychiatrist, whose common-sense view was that everyone has a job to do and should do it.

"I am a practicing physician, psychiatrist, by trade," he said. "I cannot feel that in the treatment of patients I should care to be labeled as either democratic or autocratic. I do think it is the physician that treats the patients, and not the hospital. I do not propose to tell people in other fields how they should do their jobs. I do not propose to tell the dietitian how to construct a diet, or the psychologist how to do his job. Nor, on the other hand, do I propose to call for a vote among personnel as to how I should do mine."

ANOTHER PERENNIAL bit of verbiage was also cut out of the text when an argument arose over who actually does therapy. The psychologist? The social worker? Are we reaching the point of absurdity, where, as someone observed, we should put white coats on the plumbers because so much emphasis is being put on the therapeutic role of everyone in the hospital? The following comments stopped such fruitless discussion, and led to freer use of the word "therapy" without implications that the psychiatrist's special skills were implied:

"USE OF THE TERMS 'therapy' and 'therapist' can be carried from the merely ridiculous to the simply phenomenally ridiculous very easily," a doctor observed. "Having voiced my opinion on the term, therapy, I would like to speak about group therapy. I will say that there is such a thing as group therapy, but there are also groups which are therapeutic. These do not need to be called group therapy."

He went on to give examples of groups that are therapeutic but are not necessarily group therapy:

. . . a recreational director gets a group of patients together to plan a party, and holds a series of meetings to discuss it. This presents an opportunity to draw people out, to give them a chance to participate in something, to give them a feeling of belonging, a feeling of inter-action with other people.

. . . a group is organized to discuss the problems patients will encounter when they leave the hospital. Whether this is done by a vocational counselor, a nurse, or an occupational therapist, it may be therapeutic.

"It seems to me that when we talk about therapy and therapists one of the troubles is that we start with an administrative context," another superintendent said. "We hire a music therapist. We hire a recreation therapist. We hire some specialist. But in reality what we are attempting to hire is a specialist who uses a particular mode of inter-personal relationship.

"This concept of rigid specialization becomes blended if you emphasize that their skills are simply the ones most comfortable for them to use in trying to help the patient. You focus on this goal, and not the particular specialist's medium of communicating with the patient."

One of the discussion leaders, Dr. David Harris, saw the proper objective of the mental hospital as assisting patients by restoring their self-confidence, living efficiency, and social acceptance. The basic tools of effective hospital treatment have been altered little, and may be reduced to such terms as understanding, optimism, interest, and the intelligent use of a dedicated belief in the human dignity of the mentally ill.

He saw little controversy about this, but said the additional challenge lies in the constant scrutiny of

Participants: *Dr. Alfred K. Baur, Mo.; Dr. Claude H. Butler, Pa.; Dr. Dale C. Cameron, Minn.; Dr. Wm. P. Camp, Pa.; Mr. Harry N. Dorsey, Pa.; Mr. R. Bruce Dunlap, Pa.; Mr. M. T. Eaton, Kansas; Dr. B. P. Grimes, Minn.; Dr. Wm. C. Keating, Jr., Calif.; Dr. Wesley A. Kissel, Ind.; Dr. Thaddeus P. Krush, Neb.; Dr. Charles W. Landis, Wis.; Dr. Louis V. Lopez, N.Y.; Dr. Mildred Mitchell-Bateman, W.Va.; Mr. Theo. H. Monsma, Mich.; Dr. Leo P. O'Donnell, N.Y.; Dr. Lucy D. Ozarin, Mo.; Dr. Allen H. Parker, Ore.; Dr. B. F. Peterson, Tenn.; Mr. Paul L. Reed, Kansas; Mr. S. H. Ries, Ky.; Dr. Wm. F. Sheeley, Minn.; Dr. Benjamin Simon, Mass.; Mr. Morris Squire, Ill.; Dr. Samuel Wick, Ariz.; Father E. J. Zizka, La.*

treatment efficiency with the purpose of refining and sharpening the instruments for communicating to patients an incentive to rebuild. We should look to recent developments which emphasize rehabilitation instead of institutional maintenance. Among these are remotivation groups, relatives' groups, and industrial therapy organizations.

Viewing the many specialties that have come into the treatment picture, he saw the need for proper organization of this mass of treatment forces lest it become so ponderous that it drag the patient along behind it rather than supporting the patient's own re-growth.

He asked for a discussion of specific, technical information which should be disseminated, and a re-thinking of past practices. Is hydrotherapy dead? What realistic limitations should vocational rehabilitation impose? What are the benefits of research projects? Are we tending to lean more toward therapeutic techniques that do not involve the patient-doctor relationship?

Answering Dr. Harris' question about hydrotherapy, several people expressed views on whether staff and facilities for this treatment are still essential. Among their comments were:

"I have three hydrotherapy installations going to waste because doctors are not prescribing hydrotherapy for our patients now. I would like to transform these rooms into classrooms."

Dr. Harris rejoined that hydrotherapy is used at St. Elizabeths Hospital. The feeling there is that it has some definite benefit, though no certainty exists as to how much. However, many people ask, "Why are you wasting your time with this?"

Relating information gleaned from visiting a Veterans Administration psychiatric hospital, a doctor said that six years ago there was an extremely well-equipped hydrotherapy section. The hospital was new at that time. It was soon well staffed, and carried out a full program of activities for patients. The staff found that as patients were treated as individuals and their needs met by an activities program, the need for hydrotherapy dropped. Finally, it gave way to another occupational unit. "It has been my experience in two hospitals that as you have the staff to treat patients and keep them meaningfully busy, you have less and less need for hydrotherapy," the speaker concluded.

This discussion called to mind how constantly new ideas have been brought forward, discussed, and tried in the decade of Institutes marked by this tenth meeting. The most recent ones saw discussions of open hospitals dominating conversations, and establishment of these brings many changes in assignment of personnel. When the patient's world is no longer limited to the ward, skills of personnel must be re-examined, assignments shifted, new skills developed.

If recent sessions have been historic because of their stimulation of interest in the open hospital, perhaps future researchers will note that this Institute marked the emergence of emphasis on remotivation and re-employment of mental hospital patients.

Open hospitals, remotivation, re-employment—these things bring with them clusters of specialists and sub-specialists. A roll call of those contributing to getting a patient well no longer reads doctor, nurse, ward attendant. The addition of the names of psychologist and social worker is a long accepted fact. The contributions of occupational therapist, chaplain, volunteer worker, recreational leader are acknowledged. Strong emphasis is now being put on the industrial therapist, the rehabilitation therapist. And, in addition, there is a growing list of sub-specialties, now numbering from thirty to thirty-five. Their multiplication is illustrated by recreational therapists. Where this was once a single category, many separate organized groups have sprung up. For example, we now have music therapists; and there are six therapy organizations that call themselves some form of rehabilitation.

Most mental hospital administrators work in state hospital systems. Written job descriptions are the rule. Procedures are formalized, binding, and hard to change. The rise of these many specialists, all rapidly developing vested interests, is not without complications.

"We run into a situation where an occupational therapist objects to being used as an industrial therapist," a hospital director said. "We have to spend untold hours getting people together with these divergent therapies. Since all these people are, at least theoretically, working as therapists, isn't it what they do in their inter-personal relationship with the patient that counts? If that is true, then the particular activity they carry out isn't so important, and I wonder if we don't need fewer categories."

Another observer saw the rise of these various auxiliary disciplines this way: "Each one of these disciplines has an ostensible interest, and I won't question its sincerity, in promoting the use of its particular activity for the benefit of mental patients. But also in most of them, not all, there is a craft guild situation involved which they are not going to give up very readily. It involves economies and gains and status and all sorts of things. It is a very complicated problem. All of the organizations formed by these specialities are reaching for a place in the sun."

The American Psychiatric Association's Committee on Rehabilitation is attempting to grapple with this problem. Its chairman, Dr. Benjamin Simon, said that about two years ago an inter-disciplinary study group was formed comprised of national representatives of these (about 35) various groups. Meetings are being held twice a year in an effort to sort out who should have what responsibilities in a mental hospital.

Commenting on developments, he recalled that originally a shortage of occupational therapists led to the training of ward attendants in similar skills. Professional O.T.'s fought bitterly against this development, maintaining no one should carry out such jobs except registered occupational therapists. However, recently they have inaugurated a complete program for recognition of such auxiliary aides. The plan calls for specified training and a title of "occupational therapy assistant."

In the small hospital, the psychiatrist is still able to meld and mix staff skills, even though more and more sub-specialties crop up. But in the larger hospital it is increasingly recognized that this proliferation of disci-

plines and emerging status demands special handling. Donald C. Pritchard, the second discussion leader, told how such coordination is effected in a Veterans Administration installation. He is Coordinator of Physical Medicine and Rehabilitation, a position which some state hospitals call Director of Ancillary Services. Such a person must have a working knowledge of the ancillary services and the techniques used in the particular specialties involved. He should have the respect of members of the medical staff and be able to make recommendations to them. His purpose is to assist the various services toward a common objective in the patient treatment program. In the latter stages of patients' hospitalization, he may assist in counseling and job placement.

MR. PRITCHARD saw medical leadership as crucial to the success of any plan to make full utilization of auxiliary personnel, since the physician is the captain of the team. The support of top management is also vital. In the VA, medical leadership comes from the ward physician, who initiates a therapy order sheet giving basic information about the patient, treatment methods, and objectives. To reverse the lines of communication, the therapist has progress notes and opportunities to discuss the patient's reactions with the doctor. A statement of goals or objectives for the patient is a "must" to guide ancillary personnel or they will flounder in their mode of treatment. In actual practice, Mr. Pritchard said, the therapy order sheet has become too routine to always be meaningful, but he supported the need for such instructions.

Another administrative device becoming increasingly important is a time schedule. Otherwise, with the open door policy, patients will have too much free and unsupervised time. Poor work habits will develop and prevent formulation of post-hospital plans. It is the opinion of many that the partially privileged patient is in the most critical stage of his hospitalization. Idle time is an injustice and hinders improvement.

The new appreciation of the importance of motivating the patient to leave the hospital brings a companion appreciation of the large amount of time ancillary workers spend with the patient. They are in good position to assess patients' skills, encourage increased competence, and promote the patient's re-establishment in the community. Important functions of the coordinator should be to instill mutual confidence between hospital staff groups, prevent duplication of effort, and develop methods of communication. Staff conferences, workshops, and "brainstorming sessions" are techniques being used. Inservice training courses are frequently used, but could be expanded even more. A field of activity in which ancillary personnel could and should become more active is research.

A study made in Topeka, Kansas, by Washburn University explored the present status of coordinating adjunctive therapy and predicted special post-graduate training for coordinators, who will probably be drawn from the ranks of several groups: occupational therapy, recreational therapy, or others. The quality that will lead to their selection for such training will be a broad understanding of the work, rather than knowledge of their own specialty.

Another question emerging is how representatives of the increasing army of ancillary personnel can possibly be included as a group in patient conferences. Recent years have seen new disciplines added constantly to this list and comments are now being voiced that membership may number as high as thirty. The therapeutic results are questionable.

A plea was made for keeping a therapy unit small. One doctor saw true therapy as dependent on free communication between himself and the staff. "I believe in spending a little time with each person, discussing what he is doing, how he is doing it," he said. "This is not with the idea of giving orders, but with the idea of clarifying mutual goals and securing the sort of working integration that can promote a healthier hospital environment. I don't think it can be done by paper schedules. It has to be done by people who know how to do it.

Recruiting and Retaining Personnel

High personnel turnover is the single most wasteful factor in the hospital budget. Establishment of a well-staffed personnel division can greatly reduce this waste by effective recruitment, selection and orientation, and by coordination of inservice training programs.

Discussion Leaders: Dr. T. GLYNE WILLIAMS
Mr. DAVID ZARON

MANY PSYCHIATRIC ADMINISTRATORS practice their poorest psychiatry with their own personnel. Supposed to be experts in human relations, they are now turning to others to learn how to handle people, it was stated. One participant viewed this as ridiculous. Another said it was simply belated recognition that a psychiatrist's training is entirely patient-related, and deals with handling people with emotional problems. To cope with administration and handle hospital staffs, he needs an entirely different orientation.

In a session more given over to gloom and doom than reports of success, inservice training programs came in for commendation as one positive step that can be taken to raise the level of hospital personnel. Hospital superintendents and assistant superintendents who have completed special courses were enthusiastic about them. By various schemes to provide stipends and maintenance costs, hospital systems have sought to raise the educational level and promote staff members of such variegated classes as nurses, social workers, therapists and recreational leaders, teachers, and administrative personnel.

Most systems, state or city, try to tie moral strings to such training grants, stipulating the trainee return after training. Actually there is no known legal way to enforce compliance. Reports were that most people abide by their agreement to go back to the place underwriting the training costs. Most speakers were inclined to be tolerant of the exceptions, on the grounds that training programs contribute to better hospitals. The sticky question is whether too strong an obligation does not result in an "indentured servant" status for the trainee.

In large cities, the many opportunities for training mean that large numbers of the staff are enrolled in some classes in off-duty hours. With or without stipends, personnel will make an effort to take such courses when they see it leading to staff advancement. Educational institutions, in turn, have made an effort to understand the needs of mental hospitals and have shaped their courses to the benefit of the psychiatric institutions. This is true of schools of social work, schools of nursing, and universities training psychologists.

Returning to their home hospital, recipients of stipends spread their knowledge by organizing further training courses for people under their supervision. Here the intellectual climate of the institution may nip some of their enthusiasm in the bud. If the participants' free flow of ideas is dammed up by sharp comments, the program's effectiveness ends at its beginning. Advanced training is important, but equally important is an acceptance of the free exchange of ideas.

In considering how to fill staff positions (and with some very few exceptions most hospitals have this problem), the discussion broke down into a dichotomy of professional and non-professional staffs. In this case, "professional" refers primarily to medical staffs and team members such as nurses, social workers, psychiatrists, psychologists, and occupational therapists. This is not because of any tendency to "echelon thinking" and professional snobbery, but because of the difference in personnel recruitment methods.

FOR THE PROFESSIONS, recruitment channels are almost invariably professional societies, professional schools, and individual members of the profession. For other hospital staff members, be they aides, cooks, or stenographers, the source of supply is usually the local community. In a rural community where the hospital has long been closely knit into the social fabric, you may find a high caliber of staff and minimum recruitment problems. In the same state, recruitment of similar staff categories in a large city may be a tremendous problem. In the small community, the hospital is often the chief place of employment. In the large city, the hospital competes with business and industry for its non-professional workers.

The unpleasant truth is that only in hard times is it possible for many urban hospitals to find people to

Participants: *Dr. H. E. Andren, Md.; Mr. R. K. Barnes, Md.; Dr. Eugene N. Boudreau, N.Y.; Dr. William W. Bourke, Ill.; Dr. Dean K. Brooks, Ore; Dr. Thomas G. Caunt, B.C.; Mr. R. A. Clelland, Ariz.; Dr. Charles W. Dunn, Mich.; Dr. Addison M. Duval, Wash., D.C. Dr. Arnold H. Eichert, Fla.; Mr. Charles L. France, Md.; Dr. Russell Guiss, Ore.; Dr. William S. Hall, S.C.; Mr. James C. Hodges, Mich.; Dr. Robert C. Hunt, N.Y.; Mr. Robert H. Klein, Ill.; Mr. E. G. Merten, Ill.; Dr. A. L. Olsen, Iowa; Mr. Jack L. Patterson, Mich.; Dr. Paul W. Penningroth, Ga.; Mr. Conrad W. Peterson, Minn.; Mr. S. H. Ries, Ky.; Dr. Harry C. Solomon, Mass.; Dr. William S. Simpson, Kan.; Mr. Thomas Summers, N.Y.; Dr. Robert E. Weimer, Pa.*

fill the vacancies that occur on wards and supporting departments. When industry is bidding for workers, the salary schedule in mental hospitals means jobs go begging. When there is the slightest local recession, the job roster in the mental hospital may be full.

In recruiting a professional staff, one consideration which is apt to tip the scales in a hospital's favor is opportunity for professional enrichment. Usually this means opportunity for educational training in the community, though it may mean a chance to work with a particularly stimulating staff member. In one state, a lively research program was credited with drawing doctors to state hospitals. One man saw key staff members as his chief recruiters for their own category of personnel: psychiatrists, O.T.'s, social workers, and nurses. A personnel director in a state system saw lack of definition of duties as a stumbling block to attracting psychologists to jobs. "I hear a lot of talk about the team," he said, "but there is quite a bit of dissension on this team."

No optimism was expressed about future availability of any category of professional personnel. A typical comment was: "We might as well face the facts. There are not enough people to be had." As for professional school graduates providing a new supply, comments varied from, "There are two jobs for every graduate," to "There are six jobs for every graduate." One estimate was that the supply of graduating psychiatrists would mean ten per state, certainly not enough to fill even the ranks of those retiring from the field. And beyond this, there is the certainty that many new graduates will not go into hospital jobs.

RECRUITMENT of part-time consultants was suggested as a possible answer to the shortage of professional people on the hospital staff. However, in rural areas such part-time employment may require paying the consultant both an hourly rate and some travel pay. Projected on an annual basis, this combined pay often exceeds the salaries of regular staff members, and thus poses a hazard to staff morale. To combat this, one hospital sets a ceiling on the amount of time for which any one part-time consultant will be employed. Another staff complaint is that part-time psychiatrists are usually given cases with a better prognosis. It is evident that administrators cannot afford to take a "Let them eat cake" approach to staff complaints, for the irritation may be severe enough to lead to resignations.

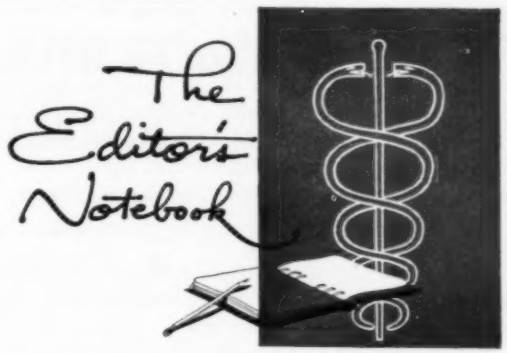
Another thorny question is whether staff psychiatrists should take patients in private practice. On the credit side of the ledger are contentions that this is an excellent source of professional stimulation as well as additional source of income, and it need not interfere with the man's work at the institution. On the debit side is the fact that it sometimes does interfere. One institution discourages private practice, insisting that in any case patients cannot be treated on hospital property. The Veterans Administration has a policy that psychiatrists may not take private patients. However, one eminent psychiatrist said, "Any of us who fired everybody who wanted to do a little private work would soon deplete his staff and be all alone."

One fresh source mentioned for personnel recruitment was part-time employment of school teachers in occupational therapy assignments. Summer employment of college students has also proved helpful.

Intelligent use of a personnel officer was another recommendation. The word "intelligent" was underscored as a result of one experience where such an officer was relegated to "pushing papers around." One doctor reported "forty per cent more time to devote to patients" after assignment of a personnel assistant.

Staff turn-over came in for its share of discussion. Some participants viewed it as a normal state of affairs. However, estimates of the definition of "normal" varied from 35 per cent to 12 per cent. Offered a magic wand which would reduce staff turn-over to zero, it is doubtful if there would be many takers.

One doctor brought a chuckle by explaining his reason for thinking turn-over can be a healthy phenomenon. Twenty new residents arrive each year at his hospital. Though so much constant change brings turmoil in its wake, the stability of steady ward assignments would bring stagnation, he said. "Doctors can get so smart they can tell which patient can and cannot be



THE FEBRUARY ISSUE of MENTAL HOSPITALS, devoted to the proceedings of the Mental Hospital Institute, has become one of the traditions of the Mental Hospital Service. In addition to our regular circulation, now nearly 13,000, copies of this issue will be mailed to everybody who attended the Tenth Mental Hospital Institute in Kansas City last October. Our special thanks this issue to Dr. F. J. O'Neill for acting as Consultant Medical Editor; Marion Robinson for Editorial Assistance; Roger Wolff for Illustrations.

I do not intend to comment at length upon the various ideas and opinions expressed by the participants and contained in these substantive accounts of the meetings. Suffice it to say that one of the principal values of the Institutes is the airing of these various opinions and the free, and sometimes excited discussion of them. It is well to remember, however, that the idea which this year seems radical may well be taken for granted next year, so swiftly are the currents of psychiatric thought flowing these days.

I will have more to say about this matter of interchange of opinion next month.

Matthew Ross, M.D.

helped. And they don't bother doing much for the people who can't be helped." He went on to say that with new staff you often find a so-called hopeless case leaving the hospital. "I think that one thing staff turn-over brings to the patient is renewed hope, renewed enthusiasm, and renewed activity." Of course, he added, there is a breaking point, where too much turn-over turns into a disaster. But some new blood is good for any institution.

WHERE THE TRICKLE of personnel leaving a hospital has swelled to a stream, many administrators have established a system of "exit interviews" to find out why. One finding reported in regard to psychiatrists was this: A man may come to a hospital to get some particular training from a staff member. Once this is obtained, salary becomes a paramount consideration and he moves on to a hospital or job offering more financial gain. A personnel man felt there was no really scientific evidence of "why," and that the American Psychiatric Association should study this.

Whether you really get the facts in an exit interview depends on the interviewer. To find the truth takes more skill than does screening for employment. When there is some depth to the talk, it becomes possible to spot internal situations which need correction.

A constructive suggestion was offered by one participant who believes that shifting of personnel is often simply a concomitant of the shifting population and that many times spouses leave a particular area because husband or wife is going to take a job somewhere else in the country. He suggested the losing hospital conduct an exit interview to recruit for the hospitals in communities to which its staff members are moving. The superintendent might send along a letter of introduction and also let other hospitals know when good workers are coming their way.

How do people on the staff feel about working in a mental hospital anyhow? Not everyone feels it is such a bad job. Those who feel it has the most prestige are those actively associated with therapy and administration. Where a hospital makes everyone feel his job contributes to getting the patient well, morale is high. Government jobs, butt of all those jokes about bureaucracy, are not universally viewed as lacking in prestige. There is some appreciation of them as prestige builders, and the thought was expressed that raising standards here has meant better professional standards elsewhere.

Civil service merit systems, pride of many a state, merited a considerable amount of criticism. Despite some admitted advantages, the fact is that in bidding for scarce personnel, the merit system representative is at a disadvantage when he has to require a candidate to take an examination.

Do union organizations lurk as still another hobgoblin on the hospital horizon? Or should the shrewd administrator embrace them, viewing unions as a lever to use in the annual budget-raising feat? Attitudes towards unions reflected personal experience and the attitudes of the community from which hospital people came. The subject elicited comments as varied as these:

"Either you get along with your unions or you don't. When you do get along with them, they are of great assistance in running an organization. They are often a great headache to administration because of the demands they make, many of which are very good but which administration cannot allow because of budgetary and other reasons. We have a meeting at least twice a year with each union, with the commissioner and all the superintendents present also. Unions now insist on having representation on up-grading of personnel. The attendants, nurses, storekeeper, and steward have to be represented on such committees. These all work extremely well."

"If you live in a unionized area how do you expect you are going to attract people into your hospital if you don't offer the things a private company would offer?"

"Unions are not an unmixed blessing. We would want to be certain that everybody understands that unionization will not solve all of our personnel problems."

"We can't just embrace unionization in government without setting the rules of the game just as has been done in industry."

"AS A FORMER personnel director in industry, I have had my share of experience. While I think the point is well taken that if you are going to compete with unionized industries you must welcome the question of unionism, I would not encourage people to run out and embrace it with open arms. You forego many management prerogatives, the opportunity to run your own hospital. You go through some traumatic experiences which you should equip yourself to handle without having the union force them upon you."

"We are in a sad state if we wait for union pressure before we adopt decent personnel procedures."

"Certainly some of the unionists look at us and say, 'You belong to your organization, the A.P.A.; nurses belong to their organization; social workers belong to theirs. Why shouldn't we belong to an organization?' "

"We have a hospital superintendent who says that when twenty per cent of his employees belong to a union he has failed in his job."

"If your employees feel the need to join together, you as an administrator must be prepared to work with them."

"If your attitude is known as one of resistance, a lack of interest and opposition, then they start immediately fighting you as the first reason for getting together."

"I sort of sense a feeling of pessimism among this group in regard to unions. When you are talking about a responsible institution union, it has advantages. The individuals will go to the grievance committee of their union. It is surprising how many things are ironed out without bothering the hospital administrator. The unions of the institutions go to the legislature, too, to work for salary plans for their people."

"We had the experience of having an attempt made at union organization. The way we handled the situation was to try to keep one jump ahead in good management practices. This union finally died on the vine."

VOCATIONAL REHABILITATION in The Mental Hospital

Because of better treatment methods, a larger number of long and short term patients can benefit from realistic vocational training. An effective program for suitable patients would decrease readmission rates.

Discussion Leader: DR. HAROLD R. MARTIN

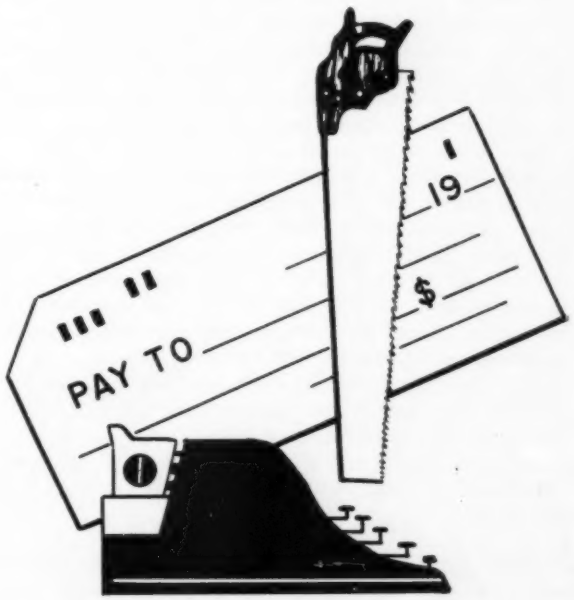
VOCATIONAL REHABILITATION is not something that is accomplished in the hospital; it is only started there and then finally accomplished in the community. A good vocational rehabilitation program in the hospital not only helps many individuals return to the community; it is often the crucial factor that permits them to remain there.

Having a job makes a tremendous difference in the way a man feels about himself when he leaves the hospital. Without a job, he feels he is a liability, an invalid, someone to be tolerated. With a job he can take his place among his family, providing or contributing to its support, and his self-respect is bolstered by knowing he is a productive member of the community. The family, too, is much more receptive to him, not only for practical, financial reasons, but because as a job-holder he is less apt to be regarded as "different."

All the hospital's reassurances that an individual has recovered from his illness, can readjust, and should be regarded as normal are not nearly so convincing as his own demonstration that he can assume responsibilities and take his place in society.

AN ADEQUATE vocational rehabilitation program has many aspects, starting with the patient's preparation within the hospital. An employment office for placing vocational rehabilitation patients in hospital jobs was suggested by Dr. Nathaniel Beckenstein. He was referring not to jobs that replace or supplement the work of regular employees, but the sort of thing that is used in industrial therapy. Such an assignment would, in essence, be the step *beyond* industrial therapy, with the emphasis upon training and evaluation rather than therapy. Having a job counselor in the hospital would make it possible to offer a report on a patient's vocational abilities and not just a diagnosis.

Dr. William S. Hall said that his hospital is finding it very helpful to have the vocational counselors working with patients during the training period, then when they try to place someone in the community they can tell the prospective employer: "I have worked side by side with this man for the past several months and know what he can do, and I believe I can say he is capable of doing the work you have for him." The counselor



can, in short, put his wholehearted efforts into selling the patient's employability because he himself is sold on it. Previously the hospital had only the services of a rehabilitation representative who would see the patient when he was declared ready for placement. The representative's efforts to place the patient were badly hampered because he had only the doctor's word that the patient was well; he had no first-hand evidence of what the patient could do in a job.

Participants: *Dr. Alfred K. Baur, Mo.; Dr. Nathan Beckenstein, N.Y.; Dr. Peter W. Bowman, Me.; Dr. Anthony K. Busch, Mo.; Dr. Wm. S. Hall, S.C.; Dr. Granville L. Jones, Ark.; Dr. Francis J. O'Neill, N.Y.; Mr. A. J. Pappanikou, Me.; Dr. Walter Rapaport, Calif.; Mr. Irving J. Schaeffer, Neb.; Dr. Lee G. Sewall, Md.; Dr. Benjamin Simon, Mass.; Dr. J. B. Smith, Alaska; Dr. George S. Stevenson, N.Y.; Dr. M. A. Tarumianz, Del.; Dr. Samuel Wick, Ariz.*

to maintenance positions. He added that he had recently

unions. It has an advisory committee of people from

An even more comprehensive rehabilitation program exists at the Arkansas State Hospital, where a special unit was established on the grounds with Federal funds. Several small buildings were remodeled and joined together to create the unit, which accommodates 60 patients and the rehabilitation staff. The program is considered an extension of clinical services, and is staffed by a psychiatrist, psychologists, and social workers as well as vocational instructors and counselors, all of whom are provided by the Vocational Rehabilitation Service of the State Department of Education. The program aims to instill social polish along with vocational competence.

The amount of information a vocational counselor has about the patients with whom he works is an important factor in how well his placement efforts succeed. In Nebraska each of the state hospitals has at least a part-time vocational counselor and they keep in touch with each other. If, for instance, a patient discharged from the Hastings State Hospital goes to Omaha, the counselor at Hastings will send a report on him to the counselor at the Nebraska Psychiatric Institute in Omaha. Also, if a patient goes to another state, the Nebraska counselor sends a report to the counselor who will be working with the patient. This exchange of information has proven very helpful.

SEVERAL PERSONS present spoke upon the advisability of moving patients from vocational training to actual jobs where they can remain under supervision until they are ready to be independent. But there was some discussion about whether these supervised jobs should be in the hospital or in the community. Several varieties of in-hospital situations were described, from the member-employee programs of the VA hospitals to sheltered workshops within hospitals, where small manufacturing jobs are done on contract from local concerns. This idea, patterned after industrial activities in British and European mental hospitals, is being tried on a pilot basis at the Central Islip (N.Y.) State Hospital. One superintendent, Dr. Samuel Wick, felt that sheltered workshops should be a community and not a hospital undertaking. He mentioned two programs in Phoenix, Arizona, one that employs discharged patients and outpatients and another that accepts hospital patients for day work. Whether the workshop is on the hospital grounds or in the city is of no import, Dr. Benjamin Simon said, so long as the community is involved in its operations.

SEVERAL COMMUNITY AGENCIES stand ready to help in the vocational preparation of mental patients. The Goodwill Industries are outstanding in this respect. In Brooklyn, the mental health association takes about six women from the state hospital's continued treatment service into its offices for clerical training. The women are given carfare, lunch and spending money by the agency, and some of them have gone on to regular jobs elsewhere. Now other social agencies in the city are giving employment to rehabilitated patients.

Nebraska is one of the states which use the sheltered workshops of the Goodwill Industries to test the vocational readiness of patients. If the hospital people are doubtful about a patient's ability to work in a regular job routine, they send him to the Goodwill shops for a month. There he can be tried out in any one or several of 95 different types of work under close observation. The careful record that is kept is used to evaluate what kind of job the patient can assume or, if he is found to be not ready for employment, to show what further vocational preparation is needed.

THE MAIN VALUE of sheltered workshops like those of Goodwill is that they permit a gradual weaning of the patient's dependency upon the hospital by showing him that he can work in the community. It would be "regressional" to confine workshops to the hospital, said Dr. John B. K. Smith, rather than having the patient work outside where the community can develop an interest in him.

Another plan to enlist community participation was tried at Middletown (Conn.) State Hospital some years ago. An arrangement was made for the patients to get vocational training at the local high school, using the school's teachers and equipment.

The one that is completely neglected in vocational rehabilitation is the housewife, said Dr. M. A. Tarumianz. Housekeeping is her job but she often knows little about it, with the result that when she returns to her home she becomes tense and self-condemnatory because she cannot do her job well. His hospital is trying to meet this problem through a homemaking course conducted by home economics specialists. Dr. Granville L. Jones added that his vocational rehabilitation unit includes a regular home kitchen where women plan, cook and serve meals under the direction of a home economics teacher. The women are also taken to a supermarket to shop for the food. In some hospitals the volunteers take women patients to their homes for this type of practice; Dr. Anthony K. Busch said this is working very well at his hospital, although at first the tendency was to take the women to homes that were above their own social and economic level.

THE FEASIBILITY of employing ex-patients in mental hospitals was discussed from legal, therapeutic and practical angles. (The discussion concerned regular employment, not member-employee programs, which are considered a phase of rehabilitation.) From a legal standpoint, the matter seems to depend on state employment restrictions, said Dr. Walter Rapaport. In California, any citizen is eligible for Civil Service appointment regardless of whether he is an ex-patient, ex-convict or ex-whatever, although the state employment application does contain a question about this. Dr. Rapaport feels strongly, however, that no state hospital should hire a former patient merely for the sake of demonstrating his competence.

Dr. A. K. Baur feels the hospital should give a former patient the same consideration any other job applicant would get, the same as it wants from other employers; on the basis of qualification. He does have a policy that no former patient is given immediate supervision of patients, which means that opportunities are limited

to maintenance positions. He added that he had recently made an exception to this policy in the case of a registered nurse, and so far she has done very well working on the wards.

One drawback to hiring a person in the same hospital where he has been a patient, Dr. Lee Sewall noted, is that he never quite gains status as an employee, never quite loses the status of patient. His hospital prefers to find jobs in other institutions for patients who are trained for hospital work.

The influence of labor unions, for good or for bad, in the vocational acceptance of former mental patients came up for discussion. Dr. Peter Bowman said he encountered some resistance in trying to place mentally retarded individuals in a unionized situation. Some of these people can accomplish only 50 to 70 per cent of what the average employee can; naturally the employer does not want to pay them full-scale wages but the unions do not like this. The result is that these handicapped persons find it even more difficult to get jobs.

Dr. George Stevenson suggested that problems of this sort be called to the attention of the Community Services Committee of the AFL-CIO. This committee is somewhat free of the ordinary employment considerations of the unions, taking a more human approach to such problems, and is in a position to interpret to the unions. It has an advisory committee of people from various health and welfare fields.

One California hospital has had little difficulty with unions since 1951, said Dr. Rapaport. At that time this hospital began inviting men from labor, industry and the professions to serve on its Volunteer Services Committee. The committee has a section on finding employment for discharged patients, and this section is headed by the leader of a labor union. An attorney for another big union serves on the Executive Council, and the committee also includes representatives of such major industries as Ford, Lockheed, electronics manufacturers and so on. The members of this group offered to secure at least one job a month for patients. They hold a monthly luncheon meeting to which they invite several new industrialists and acquaint them with the program. They also visit various industrial plants to learn what kinds of workers are needed and advise the hospital staff accordingly. When a patient is ready to leave the hospital these men talk to him and to the staff to learn what his abilities are and then introduce him to prospective employers. In addition, they have founded a sort of half-way house for working patients, which is supported by private funds. This group has been tremendously helpful and successful, Dr. Rapaport said, and its efforts have proved satisfactory to employers as well as to the hospital.

Employee Rehabilitation

By DR. WHATSISNAME

"Of course," says the friend, "this attendant was found drunk on duty. But after all, you psychiatrists are supposed to be understanding: not punitive. Sure, it's easy to fire her. But if any one has responsibility for rehabilitation, it's a hospital like yours. Don't you have a duty to determine why she drinks? And to do something constructive? If you fire her, she'll simply skid into skid row."

Then there's the employee who thinks the food is poisoned and the one who falls asleep on duty. And the one who keeps losing his keys. And all the inadequate, disturbed, unstable, litiginous, antisocial, lonesome and desperate people who sometimes carry keys in our hospitals. Have we the duty, the time, the facilities for their rehabilitation?

Most of our mental hospitals are underbudgetted, overcrowded and understaffed. If we divert a psychiatrist's time and energy from the patient to the employee, we subtract something from the patient. If we refuse to devote time to employee rehabilitation we are accused of being non-psychiatric and narrow-visioned.

Perhaps a realistic approach would be to say that it is not in the interests of patients to employ attendants who need that much rehabilitation themselves. It would seem a harsh gospel to dismiss arbitrarily the attendant who is alcoholic, dishonest, paranoid or hag-ridden by anxiety. But to keep such personnel on the roster is to hurt the patient two ways: directly by giving to these attendants enormous power over patients; and indirectly by diverting professional manpower to care for them. So it comes down to a clash of rights: the patients or the employees. And at such an intersection, there is never any doubt as to who has the right-of-way.

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MENTAL ILLNESS AND PREPAYMENT INSURANCE PLANS

Prepayment of hospital costs by insurance plans relieves taxpayers and families of an excessive financial burden: Is it feasible to extend these plans to cover hospitalization for mental illness.

Discussion Leaders: DR. D. G. McKERRACHER
DR. LOUIS F. REED

No provision for mental illness .....

Mental illness excluded .....

Psychiatric care in general hospitals .....

From 21 to 30 days for psychiatric illness .....

THE INCLUSION OF COVERAGE for mental illness in prepaid health insurance plans is undoubtedly the most controversial issue in the economics of hospital psychiatry. The controversy involves how much and even whether such coverage should be included for care in the several types of psychiatric facilities.

The problem exists not only in the United States, where all health insurance is a matter of free enterprise, but also in Canada, with its Federal Hospital Insurance scheme. The situation in Canada was described by Dr. D. G. McKerracher, starting with the social, economic, political and geographic factors involved.

By way of background, he pointed out that Canada is larger than the United States by a quarter of a million square miles, but its population is only one-tenth as large, the demographic average being five persons per square mile. The ten provinces range in size from Quebec, which is slightly larger than Alaska, down to Prince Edward Island, which is somewhat bigger than Delaware. Among and even within the provinces certain ethnic differences exist which affect interpretation of the Dominion's Constitution, the British North-American Act, in which health is specified as a provincial responsibility. ("And if you think Americans have some warm discussions about States' Rights," said Dr. McKerracher, "you should hear Canadians on Provincial Rights!")

Participants: *Mr. Carl E. Applegate, Calif.; Mr. Meindert Bosch, Colo.; Dr. Eugene N. Boudreau, N.Y.; Dr. John G. Freeman, N.D.; Mr. Robert H. Klein, Ill.; Dr. M. A. Tarumianz, Del.*

Although Canada is rapidly developing its resources, it does not yet have the investment capital to attain the level of prosperity the United States enjoys. The principle of free enterprise is not so hallowed, either, and government-owned corporations are common in Canada.

All of these circumstances have helped create a political climate suited to the growth of government-sponsored health insurance. Step by step, this has come about for general medical services but other factors have militated against including psychiatric care. Mental hospital care has long been a provincial responsibility, whereas most general hospitals are municipally operated, and quite a few others are run by religious orders. The general hospitals have had a considerable burden in caring for indigent patients, and after World War II, it became apparent that with rising costs some sort of provincial assistance was needed.

Saskatchewan was the first to develop a compulsory scheme of hospitalization. The Saskatchewan Hospital Plan went into effect in January 1948. Under it, all residents of the province, regardless of income, have all their expenses in a general hospital paid for by the province. This plan costs about $20,000,000 a year to operate for 900,000 people; nearly half of the financing is derived from a personal tax of $20 a person or $40 a family.

TWO OTHER PROVINCES followed suit with similar plans, British Columbia in 1949 and Alberta in 1950, and the federal government watched these developments with interest. Convinced of the success and value of the provincial hospitalization schemes, the government decided to encourage their adoption throughout the country, by offering to pay half the cost to any province which would set up such a plan.

The Federal Hospital Insurance Act went into effect in July 1958. All the provinces have signed up, or plan to within a year, with the exception to date of Quebec.

The cost for the entire country will run around $400,000,000 a year.

Psychiatric care has gotten short shrift in this plan, Dr. McKerracher noted, since it is covered only when given in general hospitals. Even this provision was included only after its omission was loudly protested. Whether federal support should be given also for care in the provincial mental hospitals is a subject of

lively debate among Canadian psychiatrists. Some feel it would help to improve the provincial hospitals and others feel it would only prolong these large monolithic institutions. Saskatchewan has come up with what it hopes will be a successful solution—300-bed regional psychiatric units attached to general hospitals. It is hoped the government will acknowledge these units as eligible for federal support and that they will ultimately replace the large provincial hospitals.

So far the Canadian government has not taken steps to pay medical bills incurred outside hospitals, but Dr. McKerracher thinks this will come about. At present there are two schemes for paying extramural health costs. Each province has a physician-sponsored insurance plan, similar to Blue Shield plans in the United States, which pays the family doctor for hospital, office and home calls. The amount of psychiatric coverage given under these plans varies from parity with other illnesses to complete exclusion. The other plan is a unique regional scheme which has been in force since 1946 in the Swift Current region of Saskatchewan. It is a compulsory comprehensive health insurance plan sponsored by the region, which encompasses about 12,000 square miles and has 50,000 residents. It is financed by personal and land taxes, and pays medical bills of $35 or more on a fee-for-service basis. How this plan would work for psychiatric care cannot be ascertained because there are no private psychiatrists in the region (a few cases are sent to one 150 miles away) and most psychiatric service is provided by provincial psychiatrists. The chief point about this experiment, however, is that it illustrates a compulsory comprehensive health insurance plan which works to the moderate satisfaction of doctors and patients alike, Dr. McKerracher said. Its cost runs around $650,000 for 50,000 people, which offers some indication of what the cost of a general medical and hospital plan would be for the province and for the country. The cost would run about thirty million dollars for Saskatchewan—ten million for doctors' bills and twenty million for hospital bills—and roughly six hundred million dollars for all Canada. (Extending this figure to the United States on the basis of population, Dr. McKerracher said a similar plan would cost America about six billion dollars.) And none of this, he added, includes psychiatric care other than that provided in general hospitals.

If the time comes when the Canadian government does assume the responsibility of providing all medical care for its citizens, Dr. McKerracher feels provisions for the mentally ill will be vastly improved.

THE PRESENT SITUATION in the United States is very different, of course, and Dr. Louis F. Reed undertook to explore the ways in which the cost of mental illness is borne. The big question is whether the public wants to bear the cost through insurance or through taxation, which it now does to a large extent because the major burden is carried by the state governments. If insurance coverage is desirable, and Dr. Reed thinks the consensus is that it is, is it economically feasible?

There are now about 121 million people in the United States who have some form of hospital protection, which means that about 70 per cent of the population is covered. The amount of coverage, however, varies from scanty to sufficient, sufficient at least for general illness, and is given through four types of programs. The largest number of people have policies written by insurance companies: 48 million in group plans and 28 million with individual policies. The Blue Cross and Blue Shield plans (some of which include hospitalization) account for 55 million persons. Then some five million people are covered by independent plans, which are sponsored by various industries and trade unions and by consumer and community groups. All these figures add up to 136 million dollars, Dr. Reed explained, because some people carry more than one type of hospital insurance.

THE PROVISIONS for mental illness in these plans were outlined, starting with Blue Cross. Of the 79 Blue Cross plans operating in this country, 25 of them exclude mental illness entirely, 15 allow the same amount of coverage given other illnesses, and the rest give varying amounts of protection. In general, better coverage is given for psychiatric care in general hospitals than in private or public mental hospitals. For care in general hospitals, seven plans give from 1 to 20 days; twenty-six plans give from 21 to 30 days; six give 31 to 90 days; ten allow 91 to 180 days, and ten give over 180 days.

Care in public mental hospitals is provided by thirty-seven Blue Cross plans; five allow 1 to 20 days, twenty-two give 21 to 30 days, and ten provide more than 30 days. The situation for private mental hospitals is slightly better.

Three major reasons were given by Dr. Reed for the neglect of mental illness in Blue Cross Plans. One is that the plans were initiated by general hospitals, to meet the financial problems of general illness. Second, the feeling was that psychiatric care is freely available in public mental hospitals and therefore insurance is not needed for this care. The third, and most recent obstacle is reluctance to take on the added cost of providing psychiatric treatment.

Going on to the group policies written by commercial insurance companies, Dr. Reed noted that they comprise two types. The so-called basic policies provide 30 or 60 or 90 days of benefits per admission and do not discriminate against mental illness or type of hospital. The other type, known as major medical or comprehensive medical expense policies, generally supplement the basic policies. They usually provide that after an initial deductible amount, which might be two or three hundred dollars over what the basic plan has met, the major policy takes effect and pays 70 to 80 per cent of the costs incurred by the illness, leaving 20 or 30 per cent to the patient. The major medical policies do not discriminate against mental illness, either, at least for hospitalization.

Psychiatric care outside the hospital presents a different problem, and Dr. Reed said the insurance coverage drops to about 50 per cent of the cost.

Coverage of physicians' services in the hospitals is excluded in 28 of the 72 Blue Shield plans, 16 provide

the same benefits for mental illness as for other ailments, and 25 give some coverage but less than for general conditions.

Against this background of actual practices, Dr. Reed posed some of the questions that arise about offering more insurance coverage for psychiatric care. For Blue Cross to provide, say, sixty days care for mental illness would increase premium costs only 2 to 5 per cent, he said, which is relatively little. However, for long-term treatment, which might run two or five or ten years, to be financed by private insurance, the premium costs would rise by about one-third. Would it be desirable for private insurance to take over the cost of the first sixty days, with the expense of prolonged hospitalization beyond that to be borne by the government?

IF INSURANCE COVERAGE of short-term mental hospital care is desired, what is the best way to bring this about? Blue Cross is the major holdout on this issue; should the Blue Cross plans be compelled by state legislation to provide the same benefits for mental illness as for other conditions or would it be wiser to use persuasion to get them to liberalize their policies?

Dr. Reed also mentioned the Forand Bill, which was discussed in the past Congress. It proposes to offer hospital benefits to Social Security recipients—up to 60 days of hospital care plus nursing home care beyond hospitalization, for a total of 120 days. Mental hospital care is excluded from this legislation, and Dr. Reed asked if this should be so.

Elaboration of Dr. Reed's remarks was given with slides and statistics by Dr. Eugene Boudreau, chairman of the Health Prepaid Insurance Committee of the National Association of Private Psychiatric Hospitals. He remarked that the Blue Cross and Blue Shield plans came about primarily to ward off the possibility of socialized medicine; they represent the medical profession's efforts to ease the financial strain of health protection. "Those of us who have studied the question, however, do not feel that the original purpose has been fulfilled so far as the mental patient is concerned," he said. (A statement on this situation was prepared by Dr. Boudreau's committee and circulated through the A.P.A. Mail Pouch last year. Copies may still be obtained from Dr. Boudreau, 654 West Onandaga Street, Syracuse 4, New York.)

The reason usually given for non-coverage of mental illness is that the costs are prohibitive. However, one of the oldest Blue Cross plans, in Dallas, Texas, has demonstrated that such coverage, including drug and alcohol addiction, amounts to about three per cent of the total cost.

Dr. Boudreau said that one-third of the 101,000 patients admitted to state hospitals last year were covered by Blue Cross hospital insurance. Few of them received any benefits from this insurance, which means that most were paying for something they didn't get. So far as the cost in private psychiatric hospitals goes, Dr. Boudreau said the N.A.P.P.H. has figures showing that most of the patients stay only 20 or 30 days, which means that the insurance cost would not be too steep.

If people voice a demand for psychiatric coverage there should be no difficulty in getting it included in Blue Cross policies, said Dr. Tarumianz. In Delaware the plan allows $6 a day for 30 days and an additional 30 days at $5 each, with no question of whether the illness is acute or chronic.

The principal reason such coverage is excluded, said Mr. Robert Klein, is that there is no evident demand for it. A representative of one of the largest Blue Cross plans had told him that the public feels it needs protection against physical illness but since people believe they "have some control over the occurrence of mental illness," they are unwilling to pay for extra coverage.

"Too many people think, 'It can't happen to me," Dr. Charles Bush noted. Misconceptions of this sort about mental illness are gradually being overcome by education, Dr. Reed replied, so that psychiatric care will not be looked upon as an "elective." The number of people who need mental hospital coverage is very small, he said, so that it is an appropriate insurance risk.

"Mental illness is not so prevalent as some of the conditions for which coverage is now given," added Mr. Carl Applegate, citing pregnancy as an example. The situation is brightening for mental illness. In California, about a million dollars a year is collected from insurance benefits for psychiatric care—it was less than half that just two or three years ago.

Dr. John Freeman said that in North Dakota Blue Cross was asked to offer some coverage for patients admitted to state mental hospitals. The response was negative, or at least reluctant, until more information was supplied. When Blue Cross learned that about 60 per cent of the first admissions left the hospital after two and a half months and discovered how many persons admitted held Blue Cross insurance, they agreed to pay 30 days coverage. This applies to anyone admitted to the state hospital, even alcoholics.

The provision of 30 days coverage for mental illness in Colorado did not apply to other than general hospitals until some private hospital people undertook to educate Blue Cross officials, said Mr. Meindert Bosch. After several years of endeavor, the coverage has been extended to his and another private psychiatric hospital. The selling point revolved upon cost factors, of course.

THE QUESTION OF COSTS is of crucial importance in the whole matter, Dr. Reed affirmed. If mental hospitals want benefits from Blue Cross and other insurance programs, they will have to have rather definite charges. Also, the type of hospital, its financial structure, is pertinent. "Is it altogether fair to the insurance companies," he asked, "for a public mental hospital, which provides care free of charge, to demand payment from insured patients? That is somewhat penalizing the people who have been thoughtful enough to take out insurance. If you really expect insurance plans to pay you, then you have got to demand money from the people who do not have insurance. Are you ready to be hard-boiled about demanding that everybody who gets care in your institution shall pay?"

SPECIAL PROBLEM AREAS

Recent Developments in the Treatment of Alcoholism

More hopeful attitudes toward the treatment of all phases of alcoholism have increased the responsibility of mental hospitals to provide effective treatment programs.

Discussion Leader: DR. MERRITT W. FOSTER, JR.

TREATMENT OF THE ALCOHOLIC must start with the doctor's own attitude toward the alcoholic. As one medical man put it, the subject of alcoholism is one more calculated to imbue a sense of humility than any other branch of psychiatry.

"When I first started in this work about two years ago, I thought I knew everything there was to know about it. The longer I stayed in it, the more I realized my own shortcomings. One factor involved in the treatment of alcoholics which cannot be stressed too much is the need for approaching them in an unprejudiced manner. Certainly many of us have prejudices, and we are not aware of them until after we have lost them," he said.

A Public Health Service psychiatrist, Dr. Lucy Ozarin, had attended the Yale Center for Alcoholism. She contributed a concept of the problem which she learned there: Alcoholism is a chronic disease, or can be considered as such. This idea can help doctors deal with their own emotional feelings. "We do not get angry at arthritics; we do not get angry at diabetics; we are not angry at cardiacs," she said. "But somehow this does not hold true with alcoholics. We get very much annoyed at alcoholics who do not stay sober."

Also, she urged, it is important to deal with alcoholism in its totality. The doctor can do a great deal with the alcoholic in one phase of alcoholism: when the patient needs acute medical treatment. But that does not solve the problem. Alcoholism exists in a complex of other problems—social, legal, economic. All of the people concerned with these other facets must converge in a concentrated attack to try to help the alcoholic function better.

Participants: *Dr. Freeman H. Adams, Calif.; Dr. H. H. Ashbury, Va.; Dr. Alfred K. Baur, Mo.; Dr. Eugene N. Boudreau, N.Y.; Dr. Dale C. Cameron, Minn.: Dr. Walter J. Fisher, N.S., Canada; Dr. Ernest J. Fogel, Ind.; Dr. J. J. Funkhouser, Va.; Dr. David P. Morton, Ind.; Dr. Francis J. O'Neill, N.Y.; Dr. Lucy D. Ozarin, Mo.; Dr. Benjamin Simon, Mass.; Dr. G. Edmund Stone, Va.; Dr. Sidney J. Tillim, Nev.; Dr. Cecil Wittson, Neb.; Dr. Eugene L. Wiemers, Utah; Dr. Jack A. Wolford, Pa.*

One balloon which was pricked was "the typical alcoholic" concept. There is no personality profile which represents the typical alcoholic. Alcoholics are a completely heterogeneous group, coming from every conceivable social, economic, and intellectual stratum. Q.E.D., says the diagnostician, there is no simple prescription for treatment. We should consider what we can do on an individual, rather than try to work on a collective basis.

However, psychotherapy is one approach which many feel should be emphasized, and here group psychotherapy was recommended as of greater benefit than individual sessions. One rationale for this was that it limits the intensity of treatment, which is desirable in dealing with this category of patients. Group therapy does not provoke as much anxiety, and anxiety is undesirable with an alcoholic. The alcoholic stimulated to anxiety has a ready outlet, finding the solution all too quickly in continued use of the substance we seek to have him avoid.

Motivation to change is of prime importance in psychotherapy. One doctor suggested that pre-screening of potential patients to make sure this factor was present was important. Studies have been reported citing success with as many as 80 per cent of the subjects. But this encouraging percentage was scored with patients screened by the local Alcoholics Anonymous (A.A.) group as strongly impelled to work toward cure.

Another psychiatrist said his experience in using psychotherapy had been far from this average. Taking a hard look at results, he felt absolute candor would call for this summary: only three out of a hundred actually progressed in treatment.

A psychiatrist in private practice underlined the premise that humility must be a prime quality in the doctor. "When the patient comes to my office on a voluntary basis and asks for help, my method is to admit at the first session that we do not yet know anything about the causes of alcoholism," he said. He recommended devoting considerable time to this first meeting, explaining to the patient that he will never find the doctor harsh, condemning, or unfriendly. This doctor felt psychotherapy could be effective with alcoholic patients.

Incidentally, acceptance of the importance of working with Alcoholics Anonymous groups was so strong it might almost be considered the *sine qua non* of all programs. Hospital treatment programs usually have a tie with the local society, meetings being held at the hospital with hospital staff members attending. There are also courses led by A.A. teachers. In one community A.A. has established a rehabilitation center near the hospital where patients can go for a conditional period while they are looking for work.

REACHING OUT to get assistance from all possible groups in the community is recognized as desirable. Many people rely on church leaders for help in the patient's readjustment period on leaving the hospital. Others conceded that the blue-print calling for a group cutting across many lines had obvious advantages, but not many results have been achieved in actual practice. Several committees of this type have been organized, it was reported. Annual, semi-annual, or even more frequent meetings have been held, but the only tangible result announced was support for legislation. One spokesman felt that money was the most useful assistance that could be given anyhow, and suggested one way to get this: resources derived from an increase in liquor licensing fees.

The general practitioner has become a key man in the experimental plan Nebraska has had in operation for 14 months. Dr. Wittson described this. The experiment was underwritten by the National Institute of Mental Health, and is under the direction of Dr. Jackson Smith.

The G.P.'s are paid fifty dollars an afternoon to devote their time and the time of any office staff they customarily employ to what amounts to alcoholic clinics in their own offices. Of course if a rural clinic exists, the doctor uses this facility. All comers are accepted, with the assurance that patients too difficult to handle may be referred to an appropriate hospital. The doctors determine, according to local criteria, whether the patient should be treated free or charged for services. Starting with five G.P.'s, the plan now numbers eleven scattered throughout the state.

A prime consideration was how to prepare general practitioners for this special work without removing them from their community practice for a long period of time. A four-day course of instruction was worked out at the Nebraska Psychiatric Institute, and the doctors receive further help and consultation during the course of the year. The feeling is that the program is a success.

Operating programs in several states and hospitals were described. Uppermost in administrators' minds were questions about commitment procedures, physical set-up of hospital units, length of stay, and the alcoholic's attitude toward himself as a patient.

Dr. Wolford, now at Pittsburgh, spoke on the basis of two and one-half years' experience in Nebraska. During that period, he saw approximately six to eight hundred alcoholic patients.

"We had an open ward which was autonomous, except in that the programs were mixed with all the rest of the hospital," he said.

"All patients were committed; this may not be in agreement with the thinking of many people. But we found that otherwise many patients who 'dried out' left the hospital in ten days and had no further treatment."

This, he said, led to a vicious circle: Skid Row and return to the hospital. To break this, patients were rehabilitated under a schedule calling for a minimum of sixty days hospitalization. Seventy per cent of the graduates of this regimen were able to stay out of the hospital. That is not to imply "cure." But he called it a worthwhile gauge of effectiveness, one showing the impact of such a unit. He deplored pessimism on the subject. But he conceded medical colleagues are prejudiced, and have an unfortunate disdain for the alcoholic, an attitude which merits further study.

One critic, referring to a mental hospital unit accommodating about 40 patients, remarked on a certain dependence created by such institutional regimes: "There is a group of patients who stick around because they enjoy nice living at a hospital. They have the best work assignments. They are basically psychopaths who are not too well motivated. When they leave, they go back to their old habits. In fact I think sometimes they go back to their old habits because they want to come back to the security of the hospital."

WHILE the man running a public hospital may be excused for such discouragement at times, a doctor from a private hospital pointed out that an economic test does not remove barriers to treating the alcoholic. His hospital is situated in a state where public hospitals do not accept alcoholics, unless they have a psychosis. Consequently most alcoholic care there is in private establishments.

About thirty per cent of his admissions are alcoholics, and about five per cent of the hospital population at any time is in this category. In the hospital regimen, they are assigned with psychoneurotics. There is an economic test here, in that the patients must pay handsomely for their care. There are still problems of medical management, though it is the obverse of the one cited by the tax-supported hospital. In the private institution patients want to leave before making enough progress to warrant medical discharge. And the excuse given is that they cannot afford to stay longer. This is a rationalization, the doctor pointed out, and breaking off treatment before rehabilitation simply leaves the patient caught in the revolving door.

Length of stay, and voluntary commitment or forced commitment, vary throughout the country.

Discussion Chairman Foster pointed out that in some units patients are not admitted unless they are sober,

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1. Grossman, L.: *Archives of Pediatrics, 71: 173—179, June 1954.*

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unless they want to come, unless they want help and stay on a voluntary basis.

"Now, to say that that is the best alcoholic treatment program, or that that is the nature of alcoholism, I am sure is like describing the elephant from the rear only," he said.

One comment offered is that patients who are brought in under commitment presumably are, and must of necessity be, kept longer before you have the opportunity of establishing some kind of relationship with them. It is more difficult than working with a voluntary patient, who comes in for a relatively short period of time.

A New York State doctor described a 90-bed voluntary unit in which a multi-disciplinary approach to treatment is used. A.A. orientation is stressed. A distinction is made between the psychotic and the non-psychotic alcoholic. Non-psychotic patients are admitted voluntarily directly to the unit. He feels this is useful in keeping them separate from the rest of the institution "so they will not carry the stigma of having been in a mental hospital."

"I think this is important to the alcoholic," he said. "It may not be very good mental hygiene, but I think from the point of view of enticing the non-psychotic alcoholic to come in for treatment, this is important. It builds *esprit de corps*. It separates them from the psychotics.

"We are getting a higher grade of alcoholic, if I might say that, attracting more professional people to this unit. We have been very satisfied with our approach. One thing I think that has been important is a very intensive schedule, occupying all the waking hours of the day. For we found that if we give these people much free time, not organized and structured, they get into difficulty."

In the last legislative session, New York state law was changed to allow voluntary commitment for 15 days; previously it was a mandatory 60 days. This caused some consternation among professional workers, but they have found it has caused no difficulties. The voluntary patient is still cooperative, staying at least a month, very often two, until treatment can be completed.

In answer to a question on staffing of the 90-bed unit, the speaker said it is manned by two psychiatrists, one at the supervising level and one at the senior level, with residents rotating through the program. There are a nurse, a psychologist, and teachers supplied by A.A. The staff of attendants and nurses is heavy in comparison to the staffing pattern of the rest of the hospital.

Alcoholic patients' treatment in another hospital, under a plan in operation for ten years, is completely integrated with the hospital. The admission service is on the same ward as for other admissions. True, there was difficulty at first about these patients not being given preferential treatment. However, in the course of time and after a good many meetings, the barrier dissolved.

The opinion that considerable time must be spent in treatment led to one statutory provision requiring six months' to a year's hospitalization. This was based on the premise that it was only possible to help those who, either through persuasion or choice, stay long enough to become amenable to treatment. "Some come just to stay; others come just to get sober; neither of these groups gains much by that type of approach," a doctor observed. "However we do not always use the statutory minimum. Patients are usually released within six weeks to two months. But we do require them to demonstrate some indication of well-being and a new determination to help themselves. Most patients have found some arrangement for employment before they are released.

"I believe our results are not at all discouraging.

"I would like to make two observations: Once it is established that the alcoholic is no different a human being than a sick person at any hospital, he soon learns to accept the association without feeling it is disparaging or degrading—as some alcoholics would like you to believe.

"They are very particular about what you call them. Even when you designate them as sick, they will draw a line between alcoholic addiction and drug addiction. But through staff participation in A.A. meetings and occasional discussion of the medical viewpoint, alcoholics can be helped to have a broader viewpoint on their problem and a better understanding of their relationship to other people."

Minnesota, which assigns all alcoholics to one hospital, finds the advantages of this far outweigh the disadvantages. These patients need a special program, and it is more feasible to train and staff a hospital devoted exclusively to this care. The hospital is a 200-bed unit. Any patient may be admitted on a voluntary basis any number of times as long as he stays until released. If a voluntary patient quits the hospital against advice, he must be committed to be admitted again. A committed patient is subject to the same laws as other hospitalized mentally ill people in the state. As a policy, hospitalization is limited, if possible, to 60 days. This is a fairly intensive regime, ranging through a drying out period, a counseling program with psychologists, talks with a pastoral counselor, group therapy, and A.A. meetings. A two to three-hour work program daily is set up to inculcate good work habits. The system was reported as good in every respect except follow-up after leaving the hospital; this was rated "not good."

On the score card, this hospital admits over a thousand patients a year, discharges 50 per cent of them permanently. These encompass a wide range of patients, but there are large numbers of Skid Row characters. The other 50 per cent range all the way from frequent lapses to several re-admissions.

One 2,500-bed hospital in another state has a whole building devoted to treatment of this category of patients, who comprise about 30 per cent of the institution's admissions. Emphasis is on rehabilitation, and the coordinator of the program is a recovered alcoholic. An interesting sidelight on this is that successful alumni come back to the hospital and put together radio tapes of conversations with the superintendent. These tapes are then used in the community's educational program.

Length of stay for alcoholics in hospitals in Indiana is no longer defined by law. Discharges take place when it is medically determined that the patients have re-

ceived maximum benefit. This has been found to be a much more realistic approach than the previous policy.

The pharmacological approach to treatment of alcoholics poses many questions, medical and psychological, which stir interest among doctors grappling for a solution. Experience in using the so-called barrier drugs, Antabuse and Temposil, was described.

The ethical and psychological problems created by the barrier drugs gave rise to these questions: Is the effect only psychological as some studies suggest? Or is there slight evidence of statistical improvement for groups given barrier drugs? Can the discharged patient be relied on to take such medicine? Should these be given to discharged patients by members of their families? Does this only continue an undesirable psychological dependence? Are there hazards in having barrier drugs smuggled into an alcoholic's diet? Is the drug only another rabbit's foot? Does prescribing drugs for alcoholics encourage use of a crutch by a group too prone to look for props?

The case of alcoholics is an area of treatment where more questions are asked than answered, and where answers would be welcomed by physicians dealing with these patients.

Intensive Treatment of the Senile Psychotic

Experience abroad and pilot studies in this country indicate that the senile psychotic can be effectively treated by intensive methods in or out of the mental hospital.

Discussion Leader: DR. ROBERT C. HUNT

TREATMENT of the senile psychotic should not take place in a vacuum, Dr. Robert C. Hunt, Chairman of this discussion said. The patient himself may be much less important in determining what happens to him than such environmental factors as family attitudes and economic conditions.

Sometimes we tend to think of the senile psychotic as a rather recent modern development. To show that the aged patient is not a new phenomenon, Dr. Hunt quoted from the annual report of the St. Lawrence State Hospital for the year 1896:

"It has been our experience during the past year that the tendency to commit old people is an increasing one. Advantage is frequently taken of the mental defect in worn-out members of families to dispose of them by commitment to a hospital for the insane, and especially if their own care is troublesome.

"In former years it was very rare for a case of this nature to be committed to an asylum; but with the improvement in our institutions and a corresponding increase of confidence in their management, the tendency is to burden them with all varieties of mentally defective persons that can be certified technically as insane."

Participants: *Dr. H. E. Andren, Md.; Dr. Eugene N. Boudreau, N.Y.; Dr. Dale C. Cameron, Minn.; Dr. Thos. G. Caunt, B.C., Canada; Perry Evans, R.N., Mo.; Dr. Fanny T. Ginzberg, Iowa; Dr. Logan Gragg, Ky.; Dr. C. R. Jackson, Calif.; Dr. D. G. McKerracher, Sask., Canada; Dr. David P. Morton, Ind.; Dr. Leo P. O'Donnell, N.Y.; Dr. Francis J. O'Neill, N.Y.; Dr. Thelma Owen, W.Va.; Dr. L. P. Ristine, Ohio; Dr. Wm. F. Sheeley, Minn.; Dr. Benjamin Simon, Mass.; Dr. Cecil Wittson, Neb.; Father E. J. Zizka, La.*

Dr. Hunt provided what he described as "a statistical ray of hope" with regard to the magnitude of this problem:

"I was quite surprised last week when the statistician from our department in New York State told us that his data show that the great increase in numbers of geriatric patients admitted to state hospitals was during the period of the 1930's. Beginning about 1945 it has leveled off. In fact, while our gross number of admissions in this age group is increasing, the number relative to the number of such persons in the community has actually gone down a trifle over the past ten or twelve years."

Dr. Cameron called for information on what has happened to the increment that used to come into the hospital. Has there been a compensatory increase in the number in nursing homes? Are more old people in their own homes? Or has there actually been a reduction in the number of people who have senile changes?

DR. HUNT and others feel that concrete statistical data are lacking, and that this is an area where more studies are indicated. In New York state there has been a noticeable increase in the number of nursing homes, and they are proving to be good business investments. Of course, he added, this period of leveling off of state hospital admissions has also been a period of material prosperity. This plays a significant part in determining how aged, non-contributing members of a family are cared for.

One psychological basis postulated for the difficulty families have in dealing with the senile psychotic is the reluctance of children to command their parents. This is manifestly ludicrous when the "child" is now fifty years old and the parent *non compos mentis*. But such is the power of the conditioned reflex that it is frequently difficult for the grown offspring to assume authority in deal-

ing with the parent. For this reason, the intercession of a professional worker can often help resolve the situation.

EARLY CASE FINDING could be an effective weapon against senile psychosis, providing for early treatment in a general hospital setting or treatment at home of physical disabilities that may progressively impair both physical and mental capacities.

Dr. O'Neill's hospital has a pilot project which features intensive treatment of ambulatory female seniles. At the end of two years' experience he cites rough figures showing the death rate in the treated group was 5 per cent, compared to 25 per cent in a control group. The release rate in the treated group was 25 per cent, while the release rate in the control group was 5 per cent. "We are ending up with the same number of patients in the hospital, actually, at the end of two years, but we are getting a lot of patients out of the hospital who formerly would have died there."

Based on a visit he had made to English hospitals, Dr. O'Neill said we had most to learn from their policy of utilizing a social work program to provide early case finding and treatment. He was impressed with the small number of seniles who go into mental hospitals there.

"Our experience has been that, at least in New York State, we do not get the elderly patients until they have been sick for quite a long time and have very marked physical disability as well as a lot of mental deterioration."

Another doctor related that he had once asked a psychiatrist what he should do for geriatric patients. "He gave me what I thought at the time was a facetious answer: 'Treat them in middle age."

On reflection, the hospital superintendent realized that this was good advice. Programs of physical and psychiatric care should begin before the disease process reaches its final stages.

Minnesota is experimenting with a demonstration project where older people are enlisted in what is called a Geriatric Social Adjustment Center. These people are too sick to participate in Golden Age Club activities, but they are not hospital patients. One purpose of the experiment is to relieve families of the grinding responsibility of 24-hour care. At the Center there is an activities program which takes the disabilities of the aged into account and provides for socialization. At the same time, families are given counseling to assist them in the home management of these elderly patients. The oldsters are either brought to the Center by their families or called for by volunteers. The objective of the plan is to reduce the numbers of these people sent to hospitals and nursing homes. Not enough experience has been accumulated as yet to predict the effectiveness of this approach.

A query arose as to whether family physicians view as interference the several plans calling for social workers and public health nurses to provide follow-up services for geriatric patients who have been returned to the community. One answer was that the status of these people after leaving the hospital is considered similar to that of patients on convalescent trial visit. Another view was that the general practitioner, far from fearing interference, has a negative attitude toward follow-up and after-care. Too often this is based on the physician's discouragement with what he can do for the patient. Mental hospital physicans on the other hand show an increased appreciation of what can be done for the elderly through an all-out attack on all physical disabilities.

One doctor said: "We feel continuous medical supervision is the most important factor in treating geriatric cases. We have had rather good results taking our patients immediately to the infirmary and giving them a very thorough examination first, and very thorough physical treatment. As soon as their physical condition has been brought under control, we put them on different forms of specialized therapy."

Observations about the proportion that physical conditions rather than mental contribute to the total problem are largely random. But the question suggests itself to all concerned with the subject, and the group agreed that more studies should be made on this topic.

Tied to the twin questions: "Is it predominantly physical? Is it predominantly mental?" is the further one: "Can these patients really be reached with psychiatric care?" No one recommended individual psychotherapy but some supported the usefulness of group psychotherapy, with the warning that "the going is slow, perhaps three times as slow as with other patients."

One ingredient in any program that spurs recovery of these people is attention. This may be supplied by doctors, nurses, or aides. Several instances were cited where the rate of recovery slowed when this ingredient was withdrawn.

HOSPITALS report some good results with various forms of somatic and drug therapies. Many suggestions were raised about special precautions which must be observed to prevent fatal results, as is pointed out in the medical literature on this subject.

Dr. Jackson offered what he called "four more pieces in this jigsaw puzzle" which he saw as necessary: 1. Diet: The food intake of these people is a very important element in their sustenance and therapy. 2. Nursing Care: This should include special attention to bowel function. Measures should be taken periodically to prevent constipation, or fecal impaction. 3. Occupational Therapy: Patients should become accustomed to doing something they can continue doing at home—sewing, finger painting, or some other activity that will keep them busy. 4. Social Case Work: A social worker should be brought into the case to get the patient out of the hospital, by legal means if necessary.

Dr. Gragg in Kentucky has developed a geriatric admission unit, separate from the primary admission unit. One feature of this unit is that men and women patients have separate dormitories but share a common day room. He thinks this co-educational living arrangement is beneficial.

Other doctors with experience in administering similar mixed groups said it is desirable for new admissions, but warned it is difficult to establish such a plan with patients who have long been hospitalized. In the latter case it should be done gradually, for certain reactions can be anticipated if large groups accustomed to different routines are suddenly thrown together. This refers

to patients with 20 to 60 years of institutional residence. Since these patients are senile, unorthodox personal habits may exist and these may have an adverse effect on persons newly introduced to their bizarreness. Move slowly and selectively, and these problems can be handled. Once established, a male and female living arrangement might well offer a more normal environment that is helpful to senile patients.

THOSE WHO NOTED the wide publicity given the presidential address of Dr. Harry F. Harlow at the American Psychological Association's annual meeting will recall that the subject of it was "The Nature of Love." He described experiments with monkeys in which a terry-cloth towel, warmed by a light bulb within it and also equipped to supply milk, was substituted for the animals' mothers. He concluded the psychologists had engineered an object which made a better mother than the monkey mother.

While the psychologists are busy plotting a pattern of infant care (well, infant monkey care) in which the surrogate supersedes the flesh-and-blood female, psychiatrists have not been idle in introducing synthetics into the care of the aged. Admitting he felt a little foolish in bringing the subject up, Dr. Simon nevertheless divulged the following account of how dolls have been added to the personnel roster of his establishment in Massachusetts.

"Here is something else. I am giving you this for what it is worth. Dr. Hunt wanted some hidden secrets. This sounds as foolish as possible. We had a woman in her eighties who was very agitated, untidy, and difficult to handle. Nothing we did helped. She came across a schizophrenic patient in her fifties whose family had given her a doll for Christmas. She wrestled the doll away from the schizophrenic, who, fortunately, was rather docile and let the older woman keep it. From that time on this woman became a first-rate patient. This didn't happen overnight, of course. But bit by bit she improved until she was able to go home. And she took the doll with her.

"AT THE BEGINNING we had a lot of analytic fantasies about what this meant: return of her youth; having children again; and so on. But as she got better her memory improved. Her communicativeness became normal. She told us what this meant, at least to her. It was not a symbolic thing at all. She knew that it was a doll baby, but it was something close, something near-human that she could have with her. And she became attached to it. She always recognized it was a doll.

"Whereupon we purchased a supply of dolls and handed them out. And we found other patients in this age group who responded in a similar way and improved a great deal with this curious little companion. This happened with all but those who were quite old and who were schizophrenics to begin with. To them the doll had no meaning and had no therapeutic benefit. But with the straight senile who had had a reasonably normal prepsychotic life, in several instances these dolls were beneficial."

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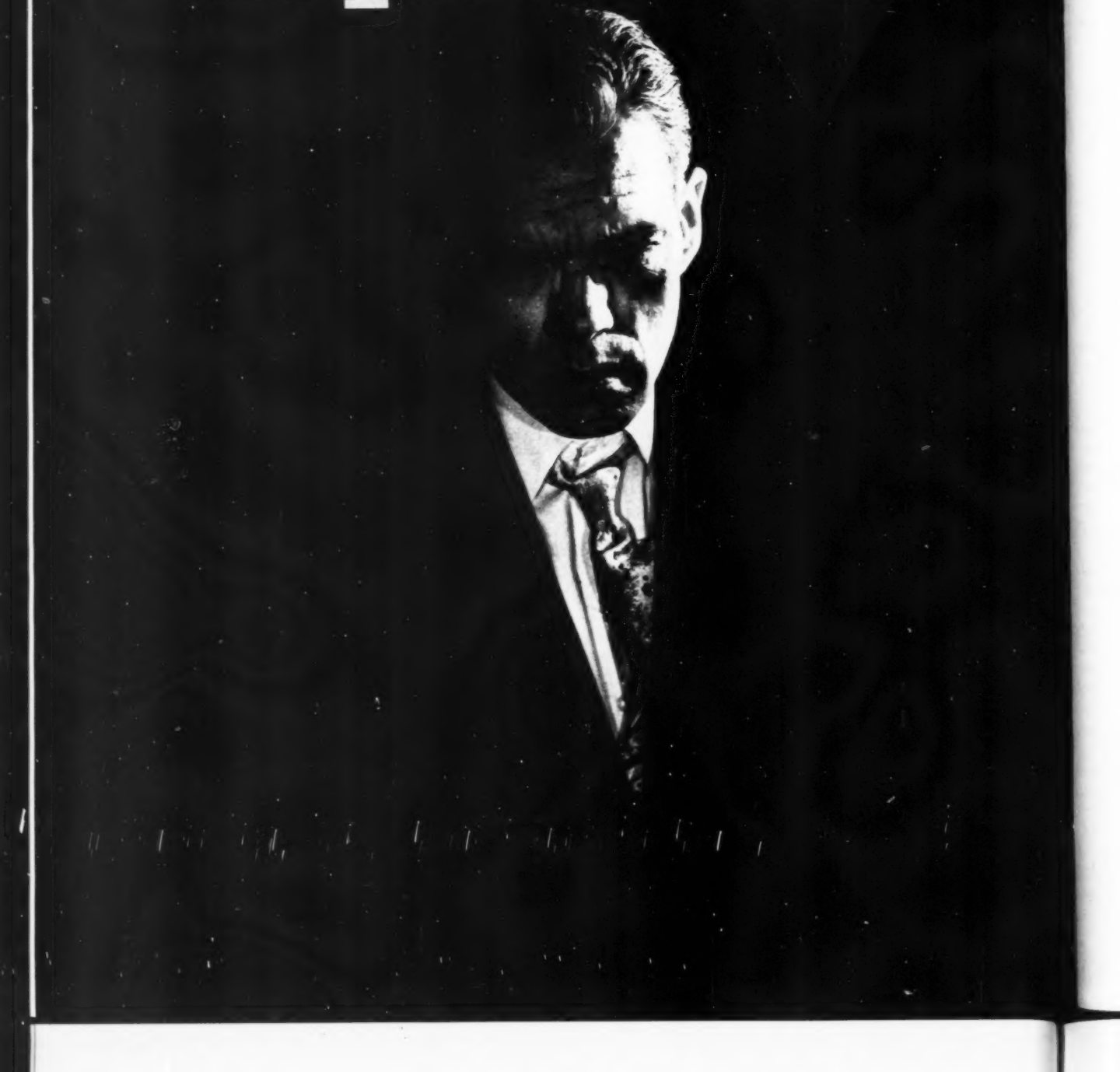

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1. Alexander, L.: Chemotherapy of depression—Use of meprobamate combined with benactyzine (2-diethylaminoethyl benzilate) hydrochloride. J.A.M.A. 166:1019, March 1, 1958. 2. Current personal communications; in the files of Wallace Laboratories.

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Application of Research Findings to the Hospitalized Epileptic

Research in the use of drugs and in the more accurate diagnosis of epilepsy has made more specific treatment possible.

Discussion Leader: DR. MELVIN D. YAHR

THE HISTORY of institutional care for epileptics is interwoven with the history of mental hospitals. Prior to about 1860 all institutionalized epileptic patients were taken care of in mental hospitals, either for the mentally sick or for the mentally defective.

About this time, a special institution for epileptic patients was established in Germany. This supposedly simulated a normal community, having constructive occupational and recreational facilities. It grew in size from a few hundred people to a few thousand. Its very apparent success was attractive to American hospital administrators and the pattern was followed in this country, many states setting up epileptic colonies.

Because of the inadequacy of medical therapy at the time, there is no doubt these colonies served a need. But as information about medical control of seizures grew and treatment became more effective, the usefulness of the colonies was questioned. In the past ten or fifteen years many states carrying out studies of the epileptic populations of the institutions found them comprised primarily of individuals with mental deficiency. Psychotic people with seizure disorders made up only a small part of the total. On the basis of these appraisals the pendulum started to swing in the opposite direction. Epileptic colonies were disbanded. Hospitalized epileptics were channeled to institutions caring for the mentally sick and mentally deficient rather than those specifically catering to the seizure problem. Many states have developed epilepsy projects providing direct services to patients as well as educational programs for lay and professional groups.

DR. YAHR noted that Ohio, California, and Michigan had been in the vanguard in developing such community aids. He himself was associated with the New Jersey program, where traveling clinics were established. In addition to medical personnel trained in epilepsy and in electroencephalography, each clinic was staffed by a psychiatric social worker, a person trained in the educational field, a person with skills in work evaluation and employment, and a vocational guidance counsellor trained in rehabilitation. Direct services to the patient were only part of the contributions made. Interpretation of the problem of the epileptic to citizens in the community, particularly possible employers and school leaders, has now been carried out by these clinics for five years. Educating this public to the concept that the seizures of the intelligent epileptic can be controlled medically has had a tremendous impact on communities. Even allowing for limitations arising because not all seizures are completely controlled, acceptance of the epileptic has grown enormously.

Participants: *Dr. Charles K. Bush, D.C.; Dr. Charles Durfn, Mich.; Dr. Richard M. Free, Ind.; Dr. Milton Kibbe, Va.; Dr. G. W. Kleinschmidt, Okla.; Dr. Thaddeus P. Krush, Neb.; Dr. Benedict Nagler, Va.; Martina Nelson, R.N., Mo.*

DR NAGLER reported Virginia has had a traveling clinic for ten years. This stems from the University of Virginia, and travels to small towns throughout the region. Primarily it serves as an advisory clinic to family physicians. Patients are seen only on referral by their community doctor, who receives consultation on treatment. This service is sponsored partly by the Association for Handicapped Children, partly by the Children's Bureau. However, Dr. Nagler saw need for much more to be done, particularly in the area of educating the public and attacking the problem of employment.

Dr. Bush related his experience several years ago in Illinois when state laws relating to epileptics were being reconsidered. At the time he was Superintendent of Dixon State Hospital. Originally started as a colony for epileptics, it had evolved into a hospital designated for the care of epileptics from all over the state and mentally retarded patients from the northern half of the state.

Epileptics at this time were committed to the hospital by law, and numbered some 500 out of a total population of about 5,000. The hospital was surveyed to determine if there was need for this special type of law governing the commitment of epileptics. Dr. Bush found that 1,300 of the hospital patients had seizures—in other words, 800 people who had been committed, not as epileptic, but as mentally deficient, were having seizures. Next, he determined how many of the 500 patients committed as epileptic were of normal intelligence, and found that there were between 60 and 65. Obviously, then, there was no need for a state law to cover 60 or 65 people, and it was decided that epileptics with normal intelligence would be committed to a mental hospital, probably only long enough to get their seizures under control. Thenceforth patients with epilepsy and mental deficiency would be committed as "mentally defective." Dr. Bush said he believes this solution has worked out very well.

Dr. Yahr, not a psychiatrist, is associated with the Neurological Institute in New York City, and is also Associate Professor of Neurology at Columbia University. He brought to the discussion many sage observations from his wide experience in research and clinical treatment of the disease. Some of the highlights of his remarks were:

EPILEPSY does not refer to a disease entity but to a symptom complex. The causes are many, and the presentation of form quite diverse. We might say in defining this disorder that it is characterized by periodic transient episodes of alteration in the state of consciousness which may be associated with convulsive movements and/or disturbances in feeling or behavior. In this definition, he said the key phrases are periodicity, tendency to recur and alterations in consciousness. He pointed out that a wide variety of clinical manifestations thus come under the heading of epilepsy, since the convulsive phenomenon may be prominent in a long list of conditions and diseases of the nervous system and, in many instances, unrelated structures of the body.

In the past two decades there has been considerable progress in the development of diagnostic techniques and methods of approaching treatment—both medical and surgical. However, he said, in almost 75 per cent of our patients with seizure disorders we still don't have a known cause.

Until this is actually defined, treatment is primarily going to be a symptomatic one, treating the patient's symptom in regard to the type of seizure phenomena that he presents. Two methods are primarily available. The first and more important of these is the use of anti-convulsive medications. The second, which applies only in certain special cases, is a surgical technique. With one or the other of these two methods most clinics are able to report from 75 to 85 per cent control or marked reduction in seizure frequency in most patients.

Turning to the hospitalized epileptic patient, Dr. Yahr felt that doctors in institutions would have the advantage of greater familiarity with the medical history and response of their patients. He said the institutional population of epileptics might be expected to fall into three categories: (a) Patients whose seizures are very severe, very frequent, and unaffected by medication. These would account, by statistics reported in the treatment clinics, for about 15 per cent of the epileptic population. (b) Patients whose seizure disorder is associated with some severe personality defect necessitating inpatient hospital care. (c) Patients whose disease process is producing such severe physical or mental handicaps that they are unable to function in the community, regardless of the state of their seizure disorders.

Unfortunately, he conceded, mental hospital administrators do not find all of their "epileptic" patients limited to these categories. There is still a great deal of misunderstanding about the nature of convulsive disorders and not infrequently commitment is accomplished merely to provide restrictive custodial care.

Pressed for views on the applicability of surgical techniques, Dr. Yahr indicated his approach to this would be very, very conservative. His expectation of success would be similarly limited. At one point he said: "I don't think the answer to the epileptic patient's seizure phenomena is going to come from surgery. It is going to come from defining the metabolic brain defects that produce seizures, and in some way rectifying these metabolic disorders."

While he sees this as the future hope, he did not hold out any promise of an immediate, push-button answer. Even with the impetus given by federal assistance through the National Institutes of Health, research is tedious, expensive, time-consuming and not always rewarding. However, data are accumulating, and he foresees eventual reports of success coming from the work now being done.

Dr. Krush asked Dr. Yahr what he could say about the specificity of a particular drug for a particular type of seizure.

RECALLING the many years of research effort which have gone into this fight for knowledge, since the introduction of Dilantin gave us our first and still one of the most potent anti-convulsant drugs, Dr. Yahr said literally thousands of medications have been screened. While laboratory tests with animals gave great hope, unfortunately these did not prove out in clinical tests with humans. There is some loose correlation between knowledge gained in the laboratory and clinical application. But this still has to be validated by whoever is testing these drugs for the seizures for which he feels they are effective. This leads to a great deal of confusion because everyone does not agree on what petit mal is, what psychomotor seizures are, and what a grand mal attack is.

"You must remember you can have any fragment of a grand mal attack," Dr. Yahr continued. "And what one physician may call a small grand mal attack might be called a petit mal attack by another. If a particular drug is reported good for use in cases of petit mal, you may find the drug is not effective when you test it with your criteria for petit mal.

SUMMARIZING his attitude, Dr. Yahr concluded: "The older anti-convulsants are still our basis for treating seizure disorders. The new medications are the drugs that should be used only when the old medications do not prove themselves effective. And I think if there has been any advance in drug therapy in the past ten years, it hasn't been so much in the introduction of new medicines as it has been in consolidating our information on the technique of using the older medications.

"This isn't a matter where you can prescribe a pill and say, 'Go ahead and take it and if it works, fine; if it doesn't we will try another pill.' This is a constant, long-term proposition of trying medications to their maximum effect, reducing them, adding another medication, pyramiding one on top of the other until you find some combination of drugs that will be effective for this particular individual. And it is a long-term proposition, especially in patients that you will come in contact with in hospital situations, to try all of the medications in their proper dosages and combinations before you can say, This patient is resistant to drug therapy."

He added a word of caution against using new compounds indiscriminately before there is full knowledge

about their toxicity and dosage based on careful experimentation.

Dr. Yahr spoke frequently of the value of the electroencephalograph as a research tool, but when references were made to detection of changes in behavior through EEG readings, he urged a temperate approach.

"I am not certain what the electroencephalogram means many times," he said. "You can go out and take a hundred normal people, normal at least in terms of personality, and not having seizure disorders, and run electroencephalograms on them and you will come up with a fair percentage of people who have abnormal electroencephalography. You can run electroencephalograms on fairly severe epileptic patients in terms of very frequent seizure disorders and you will come up with normal electroencephalography. The correlation here is occasionally quite hard to understand. Many personality defects that we see in youngsters correlate with abnormalities in their electroencephalography today which are not reproducible tomorrow. Certainly this is not a fixed pattern. I am not trying to run down electroencephalography. I think it has its place. I think it is an interesting tool, one we all use. But it must be correlated with clinical facts and with other features of the patient's state. In and of itself it is not a criterion that you can use for any real diagnosis; it is not of real value just used alone. I would sound a word of caution as to what EEG means, especially in children."

In a discussion of psychiatric care of the epileptic, agreement was reached that this assumed both medical and psychiatric treatment. Several psychiatrists reported experience with particular personality types among their epileptic patients, adding that this profile was perhaps a result of the epileptic's rejection by society and difficulties in getting employment.

Dr. Bush hypothesized that the paranoid ideation of these patients may well be brought on by the experience of their seizures. Not recalling these, yet often suffering some injury which they are later at a loss to understand, they build up their own explanation. This is apt to create a pattern of thinking that "someone" has injured them. He feels it is difficult to help epileptics gain insight into their psychological problems. Dr. Dunn, from Michigan, agreed that there is an "epileptic personality," and that psychiatric measures can be effective.

Dr. Yahr concluded the session on this note: Epilepsy is a physiological disease. Like all physiological diseases, it is tremendously affected by emotion in its frequency and intensity. Patients may receive both drug therapy and psychotherapy simultaneously. One does not preclude the other.

The Mentally Retarded—A Community Responsibility

The community has never accepted its share of responsibility for the rehabilitation and utilization of mentally retarded individuals. Educational and vocational centers at the community level might lessen the burden on institutions by making these people partially self-sustaining.

Discussion Leader: DR. PETER W. BOWMAN

"THE COMMUNITY today is more aware of its responsibility toward the mentally retarded than we psychiatrists are," Dr. Bowman charged his colleagues. Statistically, he said, the problem is gigantic: There are between five and six million mentally retarded persons in this country, according to conservative estimates; nearly 150,000 are in institutions, with many thousands awaiting admission. Clinically, the syndrome is enormously complex: it has somatic, intellectual and emotional aspects of varying intensity and quantity; it has consequences for the prenatal months as well as for old age; it presents elements of relative chronicity and, more rarely, of transience. Mental retardation is, therefore, a problem of vast professional and multidisciplinary concern.

Participants: *Dr. Freeman H. Adams, Calif.; Dr. Richard H. Anderson, Calif.; Dr. Murray Bergman, N.Y.; Dr. Dale C. Cameron, Minn.; Mr. Willard Couch, Ill.; Dr. Benjamin Goldberg, Kan.; Dr. Donald H. Jolly, Ind.; Dr. G. W. Kleinschmidt, Okla.; Dr. James H. Louisell, Mich.; Dr. Benedict Nagler, Va.; Mr. A. J. Pappanikou, Me.; Dr. W. E. Prichard, Va.; Dr. Walter Rapaport, Calif.; Mrs. Anna T. Scruggs, Okla.; Dr. Cecil Wittson, Neb.*

Despite these facts and until rather recently, said Dr. Bowman, we have lagged far behind in utilizing modern psychiatric principles, new sociological insights and advanced educational and psychological methods to deal with the problems.

"Most psychiatrists have had no training whatsoever in mental retardation. I do not know of any graduate program for three-year residencies in psychiatry where the residents are required to affiliate with an institution for the retarded for at least six months. (There are some programs where affiliation is optional.)

"When I completed my training in child psychiatry some years ago in Boston, my fellow residents and I had but the vaguest notion of what constitutes mental retardation. I now realize that we knew much less than do many well-informed lay people and legislators. Our entire two-year training program included but one visit, lasting five hours, to an institution for the retarded.

"I have met internationally known authorities in psychiatry who were more or less misinformed about the diagnostic and treatment potential of mental retardates and thought them pretty hopeless cases.

"There is not even sufficient insight among many of our colleagues that today the hospitalization of mentally retarded persons is the result of a psychiatric, medical or social emergency, and that, therefore, our primary aim is to treat the psychiatric or medical disabilities, and attempt to overcome the social difficulties so that we can reintegrate our patients into the community as soon as possible."

Touching on another problem of community import, Dr. Bowman asked the group what scientific criteria prevailed concerning eugenic sterilization of mentally retarded persons. He said he understood that one midwestern state sterilized all mentally retarded patients who were discharged. In another state institution, the patients are selected for sterilization by a so-called psychologist, whose sole preparation for his job consists of a bachelor's degree from a liberal arts college. His choices are voted upon by a board of trustees composed of laymen and one general practitioner.

Several of the doctors present expressed shock that such things were permitted to happen. One said that in most states where sterilization is used, it is done only after very careful consideration by experienced physicians. Such gross mishandling as was described is subject to legal action, he added. Another said he frequently receives questionnaires asking how many patients a year he sterilizes; his reply is that he has not done any because he has found no reason to.

Dr. Bowman expressed regret that there is still no section on Mental Retardation at the A.P.A. Annual Meeting. In fact, only recently have the professional organizations formed committees on mental retardation: the G.A.P. established one in 1956 and the A.P.A. followed suit in 1957. He voiced the hope that organized psychiatry would take further steps to stimulate interest and training in the field, and that present deficiencies in the A.P.A. standards regarding personnel and facilities for institutions for the mentally retarded would soon be amended.*

Dr. Cecil Wittson added a note of optimism to what he termed Dr. Bowman's "very realistic pessimism." The Nebraska Psychiatric Institute already has an extensive teaching and research program in mental retardation underway, and hopes to expand it even further. A special research unit is being constructed at the Institute for this purpose. One of the current studies is a pilot screening unit where all Nebraska children under six years of age who are considered mentally deficient are evaluated and, when indicated, admitted for treatment. Dr. Wittson said that having this work going on at the Psychiatric Institute, on the campus of the state medical school, has attracted the interest of other medical disciplines. Thus, he said, Nebraska looks forward to developing quite an extensive program of research in this area.

Virginia, too, is progressing in this direction, Dr. Benedict Nagler reported. Residents in neurology from the University of Virginia medical school will spend three months at his institution and he hopes a similar arrangement can soon be made for psychiatric residents. Also social workers spend a day at the medical school to become at least acquainted with the problems of mental deficiency.

Dr. Nagler said he finds that interest in mental retardation is quite widespread when the subject is properly approached. A conference on research and training of professional personnel in the field was held in Virginia last fall and it attracted 450 participants. They included not only persons engaged in the field, but also a number of psychiatrists and heads of neurology departments from medical schools.

Semantics can play a part in the amount of support that institutions for the retarded receive, noted Dr. Walter Rapaport. California found that when its colonies and schools were redesignated as hospitals, they were able to get larger appropriations and more medical staff. "When legislators think of a school, they think of teachers," Dr. Rapaport said. "When they think of a colony or home they think of housekeepers or caretakers. But when they think of a hospital, they think of physicians."

THE REQUIREMENTS for physicians are the same in all California institutions, he added. Training in mental retardation is given at Langley Porter Neuropsychiatric Center in San Francisco, and may be started at U.C.L.A. in the future.

Kansas is making an effort, through the Menninger Foundation, to give all psychiatric residents at least a week's orientation in an institution for the retarded. Externs from Kansas University Medical Center get a month's orientation, said Dr. Benjamin Goldberg.

Limitless opportunities await the psychiatrist who wants to work with mentally retarded children and adults, Dr. Goldberg claimed. His institution uses all of the treatment modalities, including individual and group psychotherapy. He does not feel, however, that all retarded patients need be treated by psychiatrists. Other disciplines also play an important part in this field, and if the institutions are designated solely "hospitals," these people are going to feel left out. The solution, he believes, is to term them "hospitals and training centers" to keep the other disciplines in the picture, without relinquishing psychiatric leadership.

Dr. R. H. Anderson said it is vital that hospitals for the retarded be fully integrated into the state hospital system. Recognition for the field is terribly important, he said, and unless the hospitals for the retarded are given the same attention in budgets and staffing as the mental hospitals, they are going to be among the "have-nots" of the program. He mentioned that a recent staffing survey in California revealed a need for a higher ratio of psychiatrists and other physicians in the hospitals for retarded than in the hospitals for mentally ill.

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* *The A.P.A. Committee on Standards and Policies of Hospitals and Clinics is reviewing a more explicit set of personnel ratios to include in Part IV: Hospitals and Schools for the Mentally Defective, of the published Standards.*

"Until we have adequate staff", he said, "we are not going to attract other professionals who will bring these hospitals proper recognition." Affiliation with universities and development of research projects are important factors, and the responsibility is largely on the hospital administration to develop a program and staff that justify recognition. Until this is accomplished, Dr. Anderson said, the university people are not going to offer to set up research and training programs in the institution.

Mrs. Anna Scruggs of Oklahoma pointed out that community aid is a two-way proposition. "We cannot expect outsiders to help us unless we are willing to be helped and to give our share," she said. "The institution certainly must open the door and let medical students, teachers, psychologists and social workers come in. We have to ask for help or we are not going to get it."

If institutions for the retarded are to be called hospitals, just what type of structure is envisaged? Will they have pediatric departments and other special units to take care of all the problems that arise in the patient population, right up to the geriatric cases? Will they, in short, be hospitals in the full sense of the word?

These questions were posed by Dr. Benjamin Simon, who said his observation was that psychoses in the mentally retarded tend to be transient. (Dr. W. E. Prichard had noted earlier that his experience was that, in about 85 per cent of the cases, emotionally disturbed retardates became stable in from three to six months in a well-regulated training program.) Dr. Simon said he felt that psychiatric care was an important part of the rehabilitation program of an institution for the retarded. One of the problems he used to find when he worked in a state hospital was that when patients from the state schools were brought in for psychiatric care there was great difficulty in getting them back to the school when they had recovered from their disturbance.

THE NUMBERS GAME

YES, the Tenth Mental Hospital Institute was the largest ever, in spite of the 29 people who registered in advance and cancelled out. (We're going to devise some form of penalty for people who do this in 1959.) Altogether, 473 people attended—6 more than in 1957, which up to now has held the record for attendance.

Of these people, only 155—about one third—spoke out in open session, possibly because six or eight people spoke at least eight times each; one or two more were moved to speech twelve times; and one energetic pluralist expressed his feelings 24 times during seven different sessions!

We don't deny that what these people said was of considerable interest and value, but we'd like to have heard more from those whose pearls of wisdom fell mostly unheard in the corridors between meetings.

Psychiatrists made up the largest group of those attending—251 of them came. The business managers numbered 97—the highest attendance yet for this group—and the nurses came 50 strong. Psychologists, chaplains, social workers, activity people and directors of volunteers represented most of the remaining 75.

Out of 49 states (Dr. "Alaska" Smith was one of the most active Commissioners present) only Idaho and Montana were missing. Hope we shall see representatives from these states next year. Commissioners or their equivalents came from 29 states. From six Canadian provinces came 21 of our Canadian friends, including the Honourable Wesley D. Black, Provincial Secretary of British Columbia.

DR MURRAY BERGMAN parried Dr. Simon's questions by saying that before we talk about mental retardation and community responsibilities, the type of facilities and programs which are needed, we must define mental retardation. If it is regarded as a condition of limited intellectual capacity, three distinct patterns are evident: it may be primarily a medical, a behavioral or a social problem. The first group consists of cases who have definite physical defects and whose mental deficiency is usually severe. "This group is no problem," Dr. Bergman said, "because they are accepted by the medical profession and their defects are the subject of much medical research."

The second group consists of retardates who present behavioral and emotional problems. Quite a few psychiatrists and other medical men, particularly pediatricians, are interested in this group, Dr. Bergman said. He himself feels that these patients should be considered a part of psychiatric practice and should be cared for in psychiatric institutions.

The third type, the social problem, is perhaps the largest group and the most neglected. These are people of limited capacity who remain in the community but are accepted only if they are working, only if they are in certain localities. State institutions do not want them; they feel it is a responsibility of the community to look after these people. But in the community neither the psychiatrists nor the social agencies want to work with them. Clinics might see them and make a diagnosis of mental deficiency, but do not want to treat them. The schools do not want them either; there is no program for them.

"Now, why aren't these people accepted? I think it is a simple problem of acceptance," Dr. Bergman said, and went on to answer his own question by saying "the trouble seems to be that nobody knows how to classify them, knows why they are called mentally retarded or what can be accomplished with them. He feels that if the educators, the clinics and the social agencies would do something for them, these people would not be the social problem they are today.

IN ILLINOIS, said Mr. Willard Couch, the state set up a commission to study the needs of the retarded. It is composed of members of the General Assembly and representatives of all interested agencies, such as the state educational system, the state medical association, the University of Illinois Institute for Research in Exceptional Children, and the United Cerebral Palsy Associa-

tion. There are obvious gaps in all of the existing programs, Mr. Couch said, and there is a real need for a stronger community program. The institutions are considerably overcrowded and there is a sizable waiting list, which to some extent could have been alleviated by a community program.

The commission has recommended several solutions. One is to have small institutions located about the state which will be available for counseling and diagnosis to community agencies. Additional day care programs are needed to supplement those now sponsored by the Council for the Mentally Retarded and those in public schools. Mr. Couch said that Illinois will draw upon the experience of Delaware, where state-sponsored day classes for trainable retardates are held throughout the state. A third solution is to have the community psychiatric clinics extend more services to the mentally retarded.

"This brings up the question of how many different and separate community facilities we should have for mentally retarded children," Mr. Couch said. "Should we have clinics especially for the mentally retarded or should not the clinic psychiatrists who are trained in child psychiatry be a little less parochial and take on those patients who come in with an I.Q. below 100? I think we have to spread ourselves a little bit across the existing agencies, rather than duplicating services."

Minnesota has taken steps to get community programs organized to take some of the burden off the state institutions, said Dr. Dale Cameron. A demonstration project, supported by the U.S. Children's Bureau, is engaged in case-finding and in developing local resources in a four-county area. The project employs a pediatrician, a psychologist, two social workers and a public health nurse. They are helping the communities set up day care centers, nursery schools, special classes in public schools, parent discussion groups and orientation programs for general practitioners.

Their task with the schools is aided by two laws passed at the last legislative session. The "Mandatory Law" requires every public school in Minnesota to provide special classes for the educable retarded, while the "Permissive Law" allows any school district to establish classes for trainable retardates. The state gives financial assistance to the school districts for these programs.

The degree to which special class facilities of this type exist in a state is usually the determining factor of what proportion of higher and lower grade retardates is sent to the state institutions. This comment was made by Dr. Donald H. Jolly, who noted that you cannot regard the mentally retarded as one kind of individual who can be dealt with in some single way.

MENTAL DEFICIENCY is a multi-faceted problem which requires a corresponding variety of facilities and approaches. He would like to see a continuum of facilities, ranging from day care centers and special school classes through to residential units, with reciprocal flow among them as the needs of the retarded individual require.

Psychoanalytic Contributions to Treatment Programs in Mental Hospitals

How to recruit and use university faculty and psychiatrists in private practice (most of whom are analysts) for assistance in training programs and service to patients in state mental hospitals.

Discussion Leader: Dr. ALFRED PAUL BAY

SINCE 1953, when Dr. Kenneth Appel was President of the American Psychiatric Association and Dr. Ives Hendricks was President of the American Psychoanalytic Association, efforts have been made on an organized basis to further cooperation between psychoanalysts and mental hospitals. Both organizations set up machinery to work toward this.

The American Psychiatric Association undertook a survey of public mental institutions to see how many were using psychiatrists in private practice, how they were using them and what obstacles, if any, there were to using them.

This survey was quite revealing, Dr. Bay said, because the very objections that some institutions raised to using outsiders were being met by other institutions. For instance, one hospital would report, "We can't get consultants from the outside because we are three miles out of town." On the other hand, in Salt Lake City they use consultants from San Francisco. So distance is a relative thing.

Again, there were some instances where institutions said, "We can't afford to pay fifty dollars an hour, or something like that." But it was found that many institutions had consultants who were paid only ten, twelve, or fifteen dollars an hour; some were even getting them on a volunteer basis. So there seemed to be few really valid excuses for not involving psychiatrists from private practice and from universities.

Meanwhile, the American Psychoanalytic Association made a survey of all the practicing analysts in the country and found that a great many of them were perfectly willing to do some teaching or some other work. A basic consideration was that they wanted to know what it was they were being asked to do!

As a result, four forums of discussion were suggested: two at annual meetings of the American Psychiatric Association, and two at Mental Hospital Institutes, to discuss problems of using the services of psychoanalysts who are not staff members in hospitals.*

ASSUREDLY the distribution of the small number of psychoanalysts is such that the very mention of the specialty conjures up entirely different images to the man from Bangor and the man from Boston. For almost all of Boston Psychopathic Hospital's senior staff members are psychoanalysts, and 20 or 30 other psychoanalysts are employed on a part-time basis. Mention of such a staff seems like pure euphoria to a state which stops its count of psychiatrists (not analysts) at seven; this for an area of 33,000 square miles.

But, as Dr. Bay pointed out, there are ways to overcome distance. Advocates of air transportation argued distance was no barrier (build an air strip at the rural hospital); there were suggestions that closed-circuit television could be used; and Nebraska was reported using a system of telecommunication to carry seminars to a three-state area.

Dr. Dale Cameron said there are four important factors to consider in getting consultants. Not subscribing with unlimited enthusiasm to the premise that distance is no longer a factor, he listed availability within a travel-time of one-half hour to two hours as number one.

Second, the cases seen by the consultants, or other activities in which they are asked to participate, must be

Participants: *Dr. Robert C. Anderson, Ohio; Dr. Alfred K. Baur, Mo.; Dr. Nathan Beckenstein, N.Y.; Dr. Peter W. Bowman, Me.; Dr. Anthony K. Busch, Mo.; Dr. Dale C. Cameron, Minn.; Dr. Robert C. Hunt, N.Y.; Dr. Thaddeus P. Krush, Neb.; Dr. Charles W. Landis, Wis.; Dr. David P. Morton, Ind.; Dr. Walter Rapaport, Calif.; Dr. Wm. Simpson, Kansas; Dr. Harry C. Solomon, Mass.; Dr. Sidney J. Tillim, Nev.; Dr. George Zubowicz, Kansas.*

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* *At the A.P.A. Council Meeting on November 21st and 22nd, the Ad Hoc Committee on Education in Public Hospitals submitted a recommendation that the A.P.A. Central Office keep on file the names of psychoanalysts willing to serve public hospitals on a consultant basis, and to make this information available to superintendents on request. Council approved the recommendation, and an announcement of the availability of this information will be made in due course.*

of interest to them professionally. For example, interesting clinical material is a well-known drawing card with medical men; Dr. Cameron remarked that the large hospital presents a veritable museum of pathology.

Third, the consultants want proper referral with sufficient information to define the problem at hand. Associated with this, they want an ongoing mechanism to assure that their recommendations are carried out when it is within the capability of the hospital to do so. There is nothing quite so discouraging as to find it necessary to repeat the recommendations of a week or a month ago because someone failed to follow them the first time.

Finally, he said, the consultant usually wants to be reimbursed for his time. "I am pleased to report that this is generally not the major motive," he said. "In fact, many of our consultants are not paid, and would not come—regardless of the sum offered—unless the first three factors mentioned were satisfied. However, our consultants' fees range up to one hundred dollars a day."

Fees for consultants may become sizable items in a hospital's budget; a Missouri hospital reported spending $60,000 a year for all categories—not just psychoanalysts. Those whose budget makes such an item out of the question were given encouragement by Dr. Bay to feel that recruitment of a psychoanalyst on a voluntary basis is not entirely impossible. He cited valuable assistance he has received from Dr. Hugh Galbraith of Oklahoma City, who drives 610 miles every other week to serve at a state hospital without compensation. Thinking that it would be useful for others to know why a successful psychoanalyst in private practice would do this, Dr. Bay asked Dr. Galbraith for a statement and this is what he wrote:

"For five years I served in a state hospital. During that time I commuted to a nearby city for work in psychoanalytic training. I learned to respect the efforts of the dedicated hospital group to the biggest and most important psychiatric job in modern times. Doctors in private practice are by comparison highly paid, and doing a relatively socially insignificant job. Those with a social conscience will do everything in their power to help out in this important job.

"Analysts are supposedly helped toward greater maturity by their analyses, and surely one of the manifestations of maturity is the possession of a social conscience. It follows, then, if analysts seem reluctant to help in state hospitals, because of their lack of information about them, perhaps they need to be re-educated as to the need.

"What can psychoanalysts do? Because they know fewer patients more intimately, they can become more acutely aware of the importance of the individual, the tendency of formal diagnosis to obscure the individual, the relative importance of environment as the incubator of mental illness, and how it can be utilized in the prevention, mitigation and perhaps cure of mental illness.

"They can become particularly aware of the evils of the impersonal approach which mass treatments are apt to encourage. If they are good teachers, they have a valuable contribution to make to a young psychiatrist, and they can become a salutary influence around a state hospital."

Topeka State Hospital is fortunate enough to be able to draw on psychoanalytic specialists from three sources in its community: private practitioners in Topeka, the Menninger Clinic, and the Veterans Administration Hospital. Dr. Simpson described the many ways such consultation is used in the hospital.

Consultant psychoanalysts from the Menninger Clinic have worked at the hospital for the past nine years. Work they have done includes conducting case conferences for inpatients and outpatients; research in psychotherapy; supervision of group psychotherapy; conducting staff seminars; and psychotherapy with individual patients. They also give some staff training to special groups, such as nurses.

When consultant psychoanalysts first began work at the hospital several years ago, they were used mainly to teach psychiatric residents. However, as time has gone on, there has been a shift toward their acting more and more as consultants to hospital staff psychiatrists. The hospital feels this has been useful in strengthening the training of staff men, who in turn pass on the benefits to residents.

These Menninger Clinic people spend approximately 100 hours per month at the state hospital, each consultant usually devoting two hours a week to the work. Since traveling time is only five minutes, distance is not a factor. The consultations cost twenty-five dollars per hour. About $30,000 is budgeted for this yearly. However, this is by no means all that is spent on consultation, the total yearly amount running up to $60,000.

Almost all the consultants have, at one time or another, been on the staff of a state hospital or a Veterans Administration Hospital, and consequently are conversant with the difficulties such large hospitals face. Most consultants feel this work gives them a sense of personal usefulness, as opposed to what is sometimes characterized as the "ivory tower atmosphere" of prolonged psychoanalysis.

Topeka State Hospital also has an arrangement whereby four psychiatrists in private practice in the town may continue to see patients in the hospital if the patient's family wishes to employ them. Administrative supervision of the patient rests with the hospital, and liaison is effected by conferences between the private psychiatrist and the ward physician. The doctor on the ward keeps the private psychiatrist informed of the developments in the patient's case, and the private physician, in turn, provides the hospital with written reports on the case at regular intervals.

In some instances, when psychotherapy cannot be scheduled for a hospital patient and the patient's family wishes such treatment to start at once, a psychiatrist from outside the hospital may be employed. The state is not involved in financial arrangements for such treatment; the family pays the private consultant directly.

Psychoanalysts are also invited to the state hospital when they come to Topeka as forum speakers for other groups. They may conduct conferences or special training sessions. Outstanding leaders in the field have been frequent visitors, since the state hospital is able to draw on the roster of the visiting speakers at the Menninger School of Psychiatry and guest scientists brought to the Menninger Foundation under a three-year grant pro-

vided through the Alfred P. Sloan Foundation, Inc. Some of these men are in Topeka for periods ranging from a week to as long as several months. Taking a leaf from Nebraska's book, arrangements are made to telecommunicate lectures to the Osawatomie State Hospital.

SOME DIFFICULTIES have been encountered in trying to convince legislators and budget directors of the necessity of having psychiatric and psychoanalytic consultants. Some budget directors and legislators feel that hiring such consultants is like bringing coals to Newcastle. Dr. Simpson said that, in spite of this, he has been able to convince government officials of the tremendous value of such expenditure of funds in maintaining high standards in the hospital and improving the quality of the staff's work. He concluded by saying that he rates the services of such consultants as among the most important contributions to the education and treatment programs of the hospital.

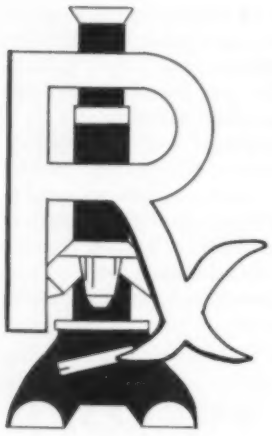
Minnesota, Missouri, California, and Indiana reported some success in recruiting consultative service from psychoanalysts. Dr. Cameron said that whereas consultant psychiatrists may see individual patients the psychoanalyst conducts a weekly staff conference. Cases are presented for their training value. Dr. Busch also reported that teaching is the primary assignment of such consultants.

Dr. Beckenstein described several ways in which psychoanalysts are used in Brooklyn State Hospital's program. The hospital employs a psychoanalyst as a consultant. Money has also been provided through a research grant to provide supervision of part of the residents' training by psychoanalysts. About twenty residents work in an outpatient night clinic, seeing patients in the first half of the evening. The consultant psychoanalysts then confer with the residents and discuss the cases, one supervisor being assigned to each three residents.

Residents get didactic training in a course arranged on a regional (Long Island) basis. They attend courses in basic psychiatry two mornings a week at the school of graduate psychiatry headed by Dr. Sandor Rado. An instructor comes to the hospital one afternoon a week for a case seminar. Dr. Beckenstein feels this is an effective way for residents to learn the principles of psychodynamics and gain experience in applying them.

Senior staff members at the Brooklyn hospital also have advanced training under psychoanalytic guidance through six-month assignments on a two-mornings-a-week basis at a clinic conducted at a general hospital. This affiliate work is under the direction of Dr. Ralph Kaufman at Mount Sinai Hospital. Staff members serve in rotation so that all have this further training.

Dr. Bay commented that continued staff training is as important as training of residents. Very often, institutions will fall into the trap of using excellent outside psychiatric consultants in training residents, and will not invest one penny in their own staff. "I think this is a shame," he said. "I think you should have the best consultants you can for the best men you have, if you want to get the most for your money."



Administration of The Hospital Pharmacy

Budget allocation for drugs has increased by leaps and bounds during the past five years. A well constituted Pharmacy Committee, working in close cooperation with the medical staff can see that drugs are effectively purchased, dispensed and administered.

Discussion Leader: Dr. GLEN J. SPERANDIO

TODAY, more than ever, a pharmacy is a necessity for every mental hospital. As in the classic recipe for pigeon pie, however, the administrator is stumped with the initial step in the instructions: First catch a pharmacist.

Pharmacists are scarce, command high salaries, and are not readily attracted to hospital positions. A recent audit of all hospitals in the United States indicates that over one-third of them do not employ any registered pharmacist. The figures do not show what the ratio is for mental hospitals, but certainly it would not be above this.

Recently the role of the pharmacy has changed even more drastically in mental hospitals than in other institutions because of the increase in treatment approaches which feature drugs. Approximately five per cent of a hospital's total expenditures are for pharmaceuticals, it was stated.

One of the chief excuses used by administrators for failure to employ a staff pharmacist is that they "cannot afford to pay a salary necessary to hold a good man." This was characterized as a poor excuse, since a professional employee can readily save money for an institution. And, too, salaries quoted often refer to remuneration without taking into consideration fringe benefits whose dollar value would add impressively to total wages. Such items as housing, medical care, and some meals may be added, for example, and it is a mistake to make comparisons with salaried non-hospital jobs not including such inducements.

One solution to the problem of supply might be for administrators to consider less stringent demands in length of experience by pharmacists. Experienced pharmacists are often unavailable, whereas a less experienced person might profitably be considered. Sources suggested for recruiting personnel include schools of pharmacy, State Boards of Pharmacy, State Pharmaceutical Associations, Hospital Pharmacy Associations, and advertisements in professional journals. There are 72 accredited schools of pharmacy in the United States, producing about 5,000 graduates each year.

ANSWERING a complaint that the older pharmacist may be "set in his ways" and not resilient enough to meet demands in an area of medicine where knowledge of pharmacological approaches is constantly growing, a speaker urged a recognition of new times by both administrator and pharmacist. Too often, he admitted, hospital jobs have been considered a refuge of the incompetent. This has helped to give the hospital job a bad name. This stigma must be removed, and an awareness must be created of the importance of the pharmacist in the therapeutic program of a dynamic psychiatric hospital.

Dr. Sperandio sketched the impact a pharmacist may have on an institution. As an expert on drug storage, the pharmacist's primary role is that of insuring safety in drug administration. Unfortunately, too many hospital authorities take drug safety for granted and have a false sense of security because accidental deaths resulting from improper drug usage are so infrequent. The administrator may well ask himself these questions: In view of the many new and powerful drugs now used routinely, do we have a qualified person supervising their distribution? Do we have adequate coverage of the pharmacy service seven days a week? Do we provide adequate space and equipment to permit the proper functioning of a pharmacy? Does our institution comply with all the rules and regulations of the various accrediting and law enforcement agencies concerning drugs? Do we have a drug formulary? Do we have a therapeutics committee and is it functioning properly? Do we have adequate reference material for the pharmacist? Does our pharmacist have sufficient time to devote to administrative duties?

The secret of proper pharmaceutical service in a hos-

Participants: *Dr. Barry A. Boyd, Ont.; Dr. Willard C. Brinegar, Iowa; Dr. Robert W. Brown, Wash.; Dr. Anthony K. Busch, Mo.; Dr. Thomas G. Caunt, B.C.; Mr. G. Frazier Cheston, Pa.; Mr. Samuel Cohen, N.Y.; Dr. Charles E. Goshen, D.C.; Dr. Donald H. Jolly, Ind.; Miss May Kennedy, R.N., N.J.; Dr. Robert B. May, Minn.; Dr. Ott B. McAtee, Ind.; Dr. Walter H. Obenauf, Mich.; Mr. Seward, Kan.; Dr. Harry C. Solomon, Mass.; Mr. Morris B. Squire, Ill.*

pital lies in successful organization and establishment of clearly defined policies of drug control. The policies should be initiated by the chief pharmacist with the help and approval of the administrator. A therapeutics committee should be established with the pharmacist acting as its secretary, and from this committee should emanate all regulations concerning drug acquisition and distribution. These regulations should be simplified and put into writing. A suggested procedure is to issue a pharmacy policy manual.

THE HOSPITAL PHARMACIST, in turn, must recognize three distinct responsibilities. First and foremost are the professional responsibilities which may be summed up in the one word "service"—to patients and personnel. The hospital pharmacist must have administrative responsibility, which includes the organization and management of his department, and recognition by other departmental heads and professional directors as a trained member of the health team. Third, the hospital pharmacist must recognize his responsibility directly to the administrator since he is in essence sharing his responsibilities. According to William S. Regan (*What the Law Says About Hospital Pharmacy;* THE MODERN HOSPITAL, May 1958, No. 5, p. 102), "The Hospital Administrator is recognized in law as the general manager of his institution, and when he . . . is acquainted with a situation in the hospital pharmacy that is inherently dangerous and might tend to result in an accident, . . . the law requires that he take emergency steps on his own authority to insure that no accident would happen in the immediate future."

The pharmacy is an area where the slightest mistake can result in a tragic happening. Courts throughout the country hold that the hospital has an obligation to run a properly organized and administered pharmacy department if it intends to offer pharmacy service at all.

With or without a pharmacist, there are certain problems common to most administrators confronted these days with a widening spectrum of drugs. How do you stock drugs for a staff encompassing all shades of opinion as to what is the best? What do you do with a stock of drugs when a physician's fancy turns to a new pharmaceutical? How can you possibly sift claims for similar drugs?

Many administrators have a therapeutics committee operating along the lines Dr. Sperandio suggested. This group makes the ultimate decisions as to when new drugs will be stocked, weighing the claims of a drug's partisans. If a new product is accepted, the usual practice is to add it to the hospital's formulary, stock it, and issue it on prescription as requested.

FLEXIBILITY in dealing with stock can usually prevent loss. While one physician may feel evidence calls for a new product, others may disagree. The physician himself may later revert to choice of the first drug. In the present state of experimentation, shifting of supplies within hospital systems may be desirable. In some states, a state pharmacist arranges for transfer of drugs from one hospital to another as demand patterns change. Some pharmaceutical houses will also allow for return of stocks, crediting their cost against other purchases.

Arrangements have been systematized in many hospitals for pharmaceutical representatives, usually called "detail men," to talk with staff physicians. The hard-pressed physician objects to being "buttonholed" while on ward duties, but may feel equally frustrated to learn he has missed an opportunity to get information he wanted. If the detail man calls only once in a year or two, the inconvenience to both can be pictured. Among procedures that have been successful are arranging definite hours of appointment, arranging space where representatives can set up exhibits and discuss their products, and arranging for desk space so detail men can talk with doctors at the room where they report for duty or where they pick up their mail. In some hospitals, the pharmacist is the liaison man between detail men and doctors, passing on information to staff members and arranging for conferences.

The statement was made that in spite of his high salary, the pharmacist will save the administrator money. How? Largely because of his purchasing know-how and efficiency in using personnel. He will be conversant with the business mechanics of drug distribution. Some companies have what is called a city-county-state policy on pricing, for example, and various discount policies prevail. The pharmacist will know when to and when not to order drugs in quantity. In some instances a discount makes a large order economical, but if this means oversupply it may also mean waste. An alert pharmacist will be familiar both with current drugs and research on new drugs. He will know about reports in current literature and research in progress. He will have an educated guess about future possibilities that will reflect advantageously in purchasing policies.

AN OBJECTION was raised that state purchasing systems often handle these purchases anyway. But many felt state purchasing systems still leave the initiative with the individual hospital, since the state agency made contracts but left the purchasers free to place the order directly with local sources. Usually all the major companies are included in the contract, giving latitude enough so that considerable choice can still be exercised.

One suggestion for saving money in drug purchases is ordering supplies by generic name. Many people characterized this suggestion as "penny wise and pound foolish," with adverse side effects consisting of delivery of inferior products, or products not enlisting staff confidence and hence not being used.

Some complaints were voiced about drugs losing potency, a fact which can only be determined by laboratory tests. If they are stamped "U.S.P.," it was countered, lack of potency could be reported to the Food and Drug Administration for enforcement action. However, this protection is limited to drugs sold in interstate commerce.

The responsibility of the pharmacist came in for some discussion. In the large mental hospital it is euphoric to suppose that a pharmacist or physician distributes drug to patients personally. The drugs may not even be administered by a nurse. They are probably given to the patient on the ward by an aide.* How can the

* *See also page 19.*

QUARTERLY CALENDAR

A.P.A. ANNUAL MEETING

1959 April 27-May 1, Municipal Auditorium, Philadelphia, Pa.

1960 May 9-13, Convention Hall, Atlantic City, N.J.

A.P.A. MENTAL HOSPITAL INSTITUTE

1959 Oct. 20-22, Hotel Statler, Buffalo, N.Y.

1960 Oct. 17-20, Hotel Utah, Salt Lake City

1961 Oct. 23-26, Hotel Fontenelle, Omaha, Neb.

Other Meetings, February, March, April, 1959:

A.M.A. COUNCIL ON MENTAL HEALTH, Feb. 21-22, Chicago

11th INSTITUTE IN PSYCHIATRY AND NEUROLOGY, Feb. 26-27, VA Hospital, Little Rock, Ark.

BICENTENNIAL MEETING ON EXPERIMENTAL PSYCHIATRY, Mar. 5-7, Pittsburgh, Pa.

SOCIETY OF MEDICAL PSYCHOANALYSTS, Mar. 14-15, New York City

AMERICAN ORTHOPSYCHIATRIC ASSOCIATION, Mar. 30-Apr. 1, San Francisco, Calif.

AMERICAN ASSOCIATION OF PSYCHIATRIC CLINICS FOR CHILDREN, Apr. 2, San Francisco, Calif.

GROUP FOR THE ADVANCEMENT OF PSYCHIATRY, Apr. 2-5, Washington, D.C.

AMERICAN ACADEMY OF GENERAL PRACTICE, Apr. 6-9, San Francisco, Calif.

AMERICAN ACADEMY OF NEUROLOGY, Apr. 13-18, Los Angeles, Calif.

AMERICAN COLLEGE OF PHYSICIANS, Apr. 20-24, Chicago, Ill.

ASSOCIATION OF MENTAL HOSPITAL CHAPLAINS, Apr. 21-May 1, Philadelphia, Pa.

AMERICAN PSYCHOANALYTIC ASSOCIATION, Apr. 24-26, Philadelphia, Pa.

ACADEMY OF PSYCHOANALYSIS, Apr. 25-26, Philadelphia, Pa.

AMERICAN ACADEMY OF CHILD PSYCHIATRY, Apr. 27, Philadelphia, Pa.

NORTHEAST STATE GOVERNMENTS CONFERENCE ON MENTAL HEALTH, April, Connecticut

pharmacist be responsible for a procedure so remote from the pharmacy? The response was that the pharmacist dispenses and inspects. A good inspection of stations where medicine is kept includes some check of "proof of usage." This is common practice, of course, for narcotics; the same system, it was explained, can be extended to any type of drugs.

SOME SKEPTICISM was expressed about the reliability of ward personnel in administering drugs, and dismay was voiced at drug pilfering which reaches noticeable proportions in some hospitals. This is particularly true where antibiotics are concerned.

One hospital administrator described a system whereby antibiotics are kept under tight control. Prescriptions for antibiotics are numbered and posted on the requisition in the drug room so that all stock is accounted for. A different system to check drug usage and make sure medicines are administered correctly was described by another participant. In this case, all medicines in the ward medicine room are marked by the patients' names; there are no stock supplies on the ward. The patient's individual medication has a notation of the doctor's original order. When the medicine is gone, the doctor must write a new order. This means the doctor also revaluates the medical situation. This suggestion led to protests from several that the system had been tried and failed because work pressures made it impractical.

Another problem aired was whether the well-run pharmacy should also contain the hospital's medical supplies such as gauzes, cottons, and surgical supplies. Opinion was divided between those believing the pharmacist could effect economies by making these supplies part of the pharmacy, and those who believed the service should be located elsewhere. Many of these supplies must be sterilized for use, and are sometimes placed in a separate supply room headed by a nurse. In some hospitals they are issued by a central supply office. Sentiment varied somewhat according to the physical lay-out of hospitals. But one point was paramount: these supplies must be available to the doctors without delay. Where residency staffs rotate often, supplies cannot always be anticipated in advance, and a system involving delays in procurement will not work. For example, sterile gloves are needed in varying sizes.

CONSULTATION on how best to set up supply of pharmacy services in the individual hospital might be sought from the following professional sources: the advisory committee of the American Society of Hospital Pharmacists; Dr. G. F. Archibald, Chief, Pharmacy Branch, Division of Hospitals, U.S. Public Health Service.

Should hospitals provide drugs to patients when they leave the hospital? Some believe they should, since this helps prevent relapse and consequently saves the hospital money. One hospital justifies the practice on the basis of the patients' status being probationary for six months after leaving.

A representative of a pharmaceutical house said this had been discussed at a trade meeting recently, and the general practice seemed to be for hospitals to provide drugs for varying periods of time, mostly about two to four weeks. In Kentucky, a ruling on the legality of the state's providing tranquilizers for post-hospital care was sought from the attorney general, who ruled it was an allowable expense since it prevented higher hospitalization costs. In most states, after the patient has been out of the hospital for several weeks, further prescriptions for medication must come from the family doctor. In places where a system of referral back to the family doctor has been instituted by the hospital, the letter of referral usually contains information about the medication the patient received at the hospital.

Housekeeping Problems of the Mental Hospital

Scientific housekeeping methods have rarely been applied to the mental hospital. There is need for a complete reappraisal and perhaps reorganization of housekeeping functions.

Discussion Leader: Mrs. HELEN K. JOHNSON

SOUL-SEARCHING SESSIONS of hospital managers are producing many new formulae for mixing the personnel ingredients of hospital staffs. In therapy, the emphasis is put on getting the patient well, remotivated, and out into society. To accomplish this economically, it is evident an analysis must be made of how persons working with the patient spend their time. Are they doing jobs that should be done by someone else?

Though the words "time and motion study" may be tossed off in such discussions, like a self-conscious scholar sprinkling an oration with foreign phrases, only one thorough-going analysis of this sort was reported in progress. What has happened, though, is that circumstances have forced a gross calculation of how people spend their time. The answer may be the startling one that 70 per cent of the time of attendants and nursing personnel is taken up with housekeeping chores. Thirty per cent of their time could not possibly cover the needs of an active therapeutic regime. Acknowledging this, many a hospital begins to call housekeeping by its own name. Realism dictates a choice of housekeeping personnel to do just that.

In this session, a professional housekeeper guided the discussion to point up what duties should be the rightful domain of such a person, and led participants to air views revealing the many divergent policies now followed.

How does the executive housekeeper fit into a hospital's table of organization? There are various answers. One large hospital uses three housekeepers in these special areas: medical and surgical, geriatrics and administration. Administratively, they are under nursing services. In other hospitals, the housekeeping department is responsible to the business executive. In one large institution the housekeeper reports to the supply officer in line of authority, but is stationed in the nursing service office to insure working liaison.

Participants: *Miss Rosa Lee Adams, R.N., Conn.; Mr. Charles T. Bailey, Mich.; Dr. Vera M. Behrendt, R.I.; Mrs. Jewelle Dugger, Okla.; Dr. Geo. A. Elliott, Mass.; Dr. William C. Keating, Jr., Calif.; Mr. Kenneth G. Kerr, Mich.; Mr. Richard Meriwether, Ky.; Mr. Delbert C. Mesner, Neb.; Miss Dorothy Morris, D.C.; Mr. Charles S. Pearson, Mich.; Dr. Arnold A. Schillinger, N.Y.; Mrs. Anna T. Scruggs, Okla.; Dr. J. Butler Tompkins, Vt.*

In reaching out to gain more time for personnel working in therapy programs, administrators are finding a need to structure the duties and responsibilities of the housekeeping division to attract worthwhile personnel.

And with these new personnel must come new methods. Housekeeping experts are constantly inquiring about new methods and new materials. They think in terms of mechanized equipment for paid helpers. They see miles of corridors and acres of living space. They think of dealing with them on a production basis, and do so. They see each surface to be cleaned as a surface with its own characteristic cleaning requirements. They want to know if cleaning instruments will pick up the dust or simply distribute it to a new place.

CATAPULTED from other environments to the mental hospital, housekeeping experts are sometimes shocked at what they find. Not all of the conditions of the exposé era have been corrected, One of them said: "Why don't we get up to date? We are living in a different age!" She said this after describing her dumbfounded reaction at seeing patients in socks polishing the floor by shuffling. She also saw cleaning being done with a blanket on a block of wood. It was a far cry from the housekeeper's textbook ideal of the washable nylon mop, whose virtues she extolled with the passion of a starving man describing a juicy steak.

"How can hard-pressed hospital people possibly test and weigh the claims of the many products that might improve institutional housekeeping?" This was the query of a professional housekeeping executive, who saw this as an important part of her job. Among the various personnel used to conduct tests of housekeeping products are nurses, laundry superintendents, and business managers. One hospital tests products on a demonstration ward where the effects of patient use can be measured. However, one business manager was a strong advocate of a staff housekeeper to conduct such experiments. He thinks a business manager is too busy "wrestling with the budget" to have such an additional claim to his time.

All were agreed that the duties of a housekeeper would be different for every institution. No two saw these duties alike. As for the housekeepers, they think in terms of schedules, of organizing duties and putting them on an efficient basis. They think in terms of the structure of the hospital, offices, therapy sections, and areas where patients live. They first break down the work along these lines, then they think in terms of work simplification within the necessary administrative areas. They recommend keeping clean rather than cleaning up. When reform is needed, they see it as something that should start from the back areas and work toward the front office rather than vice versa.

VIEWED WITH DETACHMENT, the employment of housekeeping personnel seems like a good idea. In real life, with the human element an unavoidable ingredient, there are problems never solved on paper. Personnel who are to be freed of housekeeping and thus made available for patient therapy assignments may cling to their old ways with the tenacity of a neurotic clinging to a neurosis. Describing the readjustments which took place as a housekeeper established working relationships with nurses, one candid personnel director said, "There was a good deal of sputtering back and forth."

"Sputtering" might be sparked by personnel jogged from their accustomed ways to new systems. For example, a housekeeper systematized distribution of linens. Before her arrival, many people were involved for much of the day coming and going to a linen room to get supplies. She has the linen distributed in an hour. Or perhaps a nurse has been used to having a janitor at her beck and call, and must adjust to rigid cleaning schedules. Or handling of patients' clothing may be assigned to the housekeeping department, with a resultant shift in accustomed ward routine.

One recommendation as to how this should be approached was the establishment of firm cooperation between nursing director and housekeeper. "Your nursing director will be glad to get rid of supervising responsibility," an administrator said. "After all, the nursing director has three-fourths of your hospital to supervise anyway, so she really shouldn't take on any more responsibilities, such as a large housekeeping department."

In the working out of the delicate relationships of ward housekeeping, the consensus was that the housekeeping department would take care of what might be called "house cleaning" arrangements. These would be the items which could be adapted to routine: preservation of floors, cleaning windows and walls, high dusting, cleaning of light fixtures, and so on. All were agreed that hour-to-hour pick-up, the sort of housekeeping that must go on twenty-four hours a day in a busy hospital, would still of necessity be the domain of the ward personnel.

One administrator voiced this complaint based on experience in trying to synthesize the work of housekeeping and nursing personnel: "When we attempted to place housekeeping on the wards, we found the nursing service, not having to clean up many of their own messes, tended to become more careless, both in the use of materials and in the general procedure. They never worried about the before and after, just the immediate procedure. This became very costly, because if you don't have to be responsible for the full gamut of what you do, your overhead cost goes up. From an original staffing of two housekeepers and twenty nursing personnel, the cry kept going up for more and more housekeepers without any appreciable reduction in nursing personnel. It seemed to me that nursing personnel just became more careless and left more for housekeeping to do. The solution to this was to say that in this area anything directly related to the patient, whether cleaning up the dining room or changing beds, was part of the nursing service."

Another administrator deplored the implication that nurses might become lazy and careless. "It is a question of dividing the supervision and dividing the responsibility," he said. "When we do that, we get a good job done."

Another question is, who should train personnel in housekeeping methods? Is it included in training for aides and nurses? Does the housekeeper conduct the training or does a nurse? Patterns are shifting, but most people reported some attention was given to this training under the direction of a nurse. Only where there were full-time, paid housekeeping aides was training directed by the housekeeper. Enthusiasm for training in housekeeping was expressed by a representative of an institution for the retarded, who described this subject as "the biggest chapter in the teaching manual." This led to a rejoinder by a nurse from a large metropolitan mental hospital, who said with some asperity that patient care was the thickest part of their text-book.

THE WHOLE QUESTION of whether patients in mental hospitals should or should not be used in housekeeping duties is controversial. Some hold that as a matter of psychiatric sophistication this type of work has nothing to do with getting the patient well. The opposing school of thought is, "Mopping, too, can be remotivation." A representative from one state elicited laughter from the audience when he said, "Housekeeping may not be patient therapy in your state, but in my state I am sure it is." A complaint was that if patients have nothing to do in the hospital they cannot be returned to working jobs in the community.

Too many times John Doe says, "Mary does not want to stay home. She dislikes washing, ironing, and cleaning the house. Me and the kids have it all to do. And Mary wants to come back to the hospital." This conversation with a former patient's husband was reported by a superintendent advocating some ward responsibilities for patients. A hospital program that encourages lethargy was viewed as inevitable if there is no participation in hospital housekeeping chores.

To tread the thin line between exploitation and therapy, one philosopher suggested this formula: "Use of patients to do housekeeping sometimes masquerades under the guise of therapy when it is actually a way of meeting a budgetary shortage. I think it is fine when a therapy course can be devised around a housekeeping program that uses patients. I will buy this when the person tells me that he has enough paid personnel so he *could* do the job without patient help. If not, I think the therapy may be suspect."

Administrative Controls of Material

A standards committee can set quotas for ward supplies and linens. Pre-printed requisitions have advantages. A qualified Administrative Assistant should be responsible for coordination.

Discussion Leader: Mr. ALEXIS TARUMIANZ

To open the discussion of this topic, Chairman Tarumianz described the system now in effect at his hospital, pointing out that it is the only medium sized hospital for the mentally ill in Delaware.

About two years ago all of the non-medical activities of the hospital were split up and placed under the supervision of administrative assistants to the business administrator. There are now three of these assistants, each responsible for several areas of the hospital operation. One is charged with personnel, accounting, housekeeping, the commissary and the store; another has warehousing, maintenance and grounds; the third one has charge of purchasing and dietary. All of the miscellaneous other little things are split up among these three, who are also responsible for improving methods and procedures in their own areas. Mr. Tarumianz stated facetiously that this left the business administrator with nothing to do but play golf.

The administrative assistant in charge of warehousing is able to allot probably fifteen or twenty per cent of his time to this function. As do all of the administrative assistants, he reports directly to the business manager, and this increases the official status of the warehouse. It is often difficult for the average warehouse man, housekeeper or inventory clerk to deal efficiently with the director of nurses, ward supervisor, chief engineer, etc. The administrative assistant, on the other hand, has a status equal to that of a large department head and the prestige of his position reinforces his ability to communicate and share ideas with other department heads. This in turn results in a closer knit over-all organization.

In most cases, whether it be soap or sheets or pillow cases, a quota is set up for a given ward. The quotas are determined by a standards committee, which includes the administrative assistant in charge, the director of nurses, the housekeeper, staff nurses of supervisory level and a psychiatric aide. On the basis of these fixed quotas the ward nurse or the charge attendant orders supplies. The quota system has proven especially useful in light of the continual change of personnel on the wards. Formerly, a nurse might start work on a Wednesday and on the following Monday learn she was supposed to requisition everything from toilet paper to prescribed forms. She had no idea of how much she needed, when she might expect delivery of the items, or even where she was supposed to get them. Other ward personnel were of little assistance, since the turnover there is even greater than in nursing. It was quite a hit and miss operation.

Participants: *Mr. R. K. Barnes, Md.; Mr. William Brenizer, Ind.; Dr. Claude H. Butler, Pa.; Mr. George E. Chamberlain, W.Va.; Mr. R. A. Clelland, Ariz.; Dr. Maurice Demay, Sask.; Mr. R. Bruce Dunlap, Pa.; Mr. Charles L. France, Md.; Dr. Salvador Jacobs, Calif.; Mr. Arve Lee, Va.; Mr. A. L. Maines; Dr. Ralph Meng, Iowa; Mr. E. F. Merten, Ill.; Mr. Charles P. O'Connell, N.Y.; Mr. R. A. Peters, Mich.; Mr. Conrad W. Peterson, Minn.; Mr. L. G. Schneider, Iowa; Dr. Eugene L. Sielke, Pa.; Mr. A. C. Yopp, Ark.*

The new requisition forms show the type of items available, in standard nomenclature, as well as the quota for a given ward. Ordering is but a matter of checking supplies on the ward and marking the necessary items on the form, in line with the assigned quota. These requisitions are then sent to the warehouse where they are approved by the administrative assistant and filled by the warehouse man. Thus fairly reasonable control is possible where quotas have been established.

Although at one time there was an attempt to eliminate trade-ins, they were found to be necessary in some cases. Now items such as mop buckets and brooms must be traded in, the old for the new. When the trade-in system was in abeyance, three times as many brooms and five times as many mop buckets were being requisitioned and equipment would be found stockpiled in ward closets.

Hoarding is further minimized through spot checks by the administrative assistant, both in his warehouse and on the ward. But over and above that there is a housekeeping division with a housekeeper and several assistant housekeepers who go out on the ward, preferably once a month, and make a check on everything pertaining to supplies and equipment. Immediate control of proper use of supplies and equipment is mainly accomplished through this housekeeping inspection.

Ward housekeeping is a nursing department responsibility, but the supplies for it are the responsibility of the housekeeper. She is the one who is charged with seeing that supplies are adequate and properly used, and that the flow of material is maintained. There is a very good relationship between the housekeeper and the nursing department and they have a mutual appreciation of each other's problems.

The question was raised as to whether the housekeeper, in telling nursing personnel what to do and what not to do with supplies, is not usurping authority which rightly belongs to the director of nurses, thus creating more antagonism than good will.

Mr. Maines described the manner in which Logansport has solved such a problem. One member of the nursing service, usually the assistant director of nurses, serves also as a member of the housekeeping department and she is the one who serves on the inspection team for wards. This is true, too, of the pharmacy department, one of whose members is assigned to housekeeping for the inspection of drug cabinet supplies.

Mr. Tarumianz reiterated his belief that friction between the housekeeper and the nursing department is not a serious problem in his hospital. He pointed out that the housekeeper who spends full time checking ward supplies and their usage also builds up a relationship between the attendants and ward nurses and the housekeeping and warehousing sections. As a part of the three-day orientation operated by the nursing office for new attendants, the housekeeper gives a two-hour talk explaining her function and telling something about how supplies flow through the hospital.

The chairman closed off this part of the discussion by stating that after all housekeeping is a part of the business department. The whole business department is there to serve the nurses and the doctors, so this is merely a section of the business department functioning as it should.

"We are all working in situations where there is considerable emphasis on medical research, and I wonder if at Delaware you are doing anything by way of research in management," asked Mr. Peterson. A negative answer by the chairman shifted the discussion to representatives from other states. Mr. Clelland offered a report on products research conducted in the Arizona State Hospital. He cited an article in the June 1958 issue of MENTAL HOSPITALS,* which described research in janitorial products. "This is a good example, incidentally, of a combined effort by nursing service and housekeeping service," he said. "They selected two areas of flooring, divided each area into sections and treated each section with a different kind of floor wax. Thus they were able to observe the comparative wearing properties of the various waxes. They also tested products used in cleaning asphalt tile surfaces. Their findings indicated that we could narrow down the more than twenty-five products offered us to about four cleaners and four waxes. Furthermore, the nursing service personnel, having participated in the project, caught the idea and now instead of measuring by so many "glugs," they are measuring by ounces. This could result in a savings of over $10,000 a year in waxes and cleaners alone."

Mr. Yopp advised the group that for a good many years his hospital has been developing administrative controls through the use of IBM mechanical equipment. He described this as a magnificent way for an institution to keep a constant control of materials and supplies, and pointed out that the equipment can also be used in the field of statistical data, research projects, etc. This brought on a lively discussion of the relative values of various mechanical devices being used to control property inventories.

Dr. Jacobs initiated a series of comments about pilfering of supplies, a big problem in every large institution. He agreed that most hospitals have good methods of controlling materials going into the central supply area, but wanted to know what means were being taken to cut down losses after the supplies were issued out to using departments.

Chairman Tarumianz suggested several expedients for minimizing petty thievery. For instance, such a simple little thing as unwrapped soap rather than wrapped soap can cut down the loss on that particular item about ten per cent. It's just that much more unpleasant for people to carry unwrapped soap.

Mr. Merten recommended linens with the name of the institution woven into the material as is done in many hotels. He pointed out that people can clip a small marked corner from a sheet or pillowcase or towel and still have a perfectly usable item, whereas they are somewhat reluctant to use the ones which plainly show they were "borrowed."

There was general agreement that the best insurance against major pilfering consists of large, well-lighted parking areas, preferably patrolled and at some distance from the building.

Mr. Tarumianz again referred to the regular inspections carried out by his housekeeping department. Supplies are checked often enough so that any great loss would be immediately apparent and this in itself is a deterrent to major theft. The inspection team does not, however, concern itself with minor discrepancies in linen count since these can be attributed to many causes other than pilfering. Some sheets will be in the laundry, for instance, at the time of counting; others will have been torn up or flushed down toilets by destructive patients.

Mr. O'Connell discussed means for reducing food pilferage, stating that his hospital has a system which has proved quite effective. Supplies are purchased on a basic food plan which allows each kitchen so much beef, so many vegetables, etc., on the basis of the number of people served by that kitchen. In addition, the dietitian maintains portion controls so that there is very little opportunity for waste or theft.

Still on the subject of food controls, Mr. Lee told the group that his hospital employs a qualified food service director with training and background both in personnel management and in food service. This employee sets up and maintains controls on farm-produced meat products and the institution has experienced no difficulties in this area.

There was general agreement that no controls are foolproof and that in the end all institutions have to depend on the honesty of their own employees.

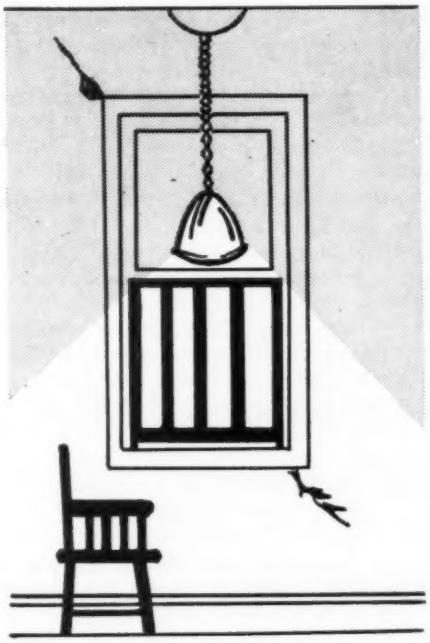
The discussion drew to a close with commentaries on what goals each institution is shooting at in material control. Most participants admitted ruefully that their goals had to be the dollar and cents limits set by the legislature. However, chairman Tarumianz had a different comment. "Our goal has very little to do with dollars and cents. We are not too concerned with how much money we are spending as long as we are getting results with the patients. We haven't accomplished it yet, but our primary goal is good living conditions and good medical treatment on the ward for all the patients."

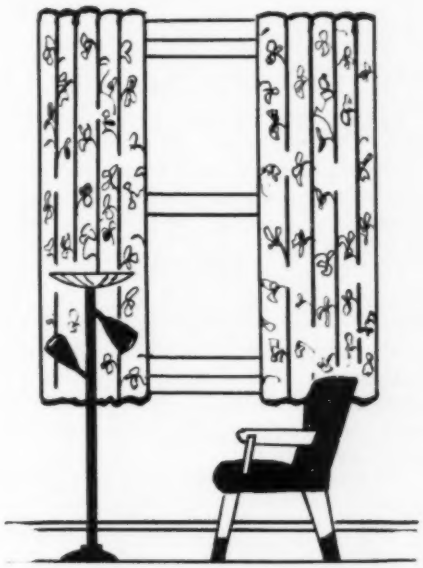
* *Vol. 9, No. 6, p. 34.*

ADAPTATION OF OLD BUILDINGS TO NEW NEEDS

During this period of rapid development hospital superintendents face the problems of running new programs in old unsuitable buildings. What interim measures can be employed to make them serviceable for present requirements?

Discussion Leaders: **Dr. CHARLES E. GOSHEN**
Mr. ANGUS McCALLUM





THE IDEAS PRESENTED at this session by Charles E. Goshen, M.D., who heads the A. P. A.'s Architectural Study Project, have already been published in the December 1958 issue of MENTAL HOSPITALS (Vol. 9, No. 10, p. 35). Consequently, the reader's familiarity with, or access to, these concepts will be assumed.

Sharing the platform, a consultant architect, Angus McCallum, discussed remodeling of mental hospitals from the viewpoint of his profession. He made it clear at the outset that in some instances the better part of valor may be not to remodel but to demolish, and admitted that this statement might brand him as a radical.

"I have had the experience myself of sitting before a budget committee and saying, 'We have to tear the building down," he said. "That is about as un-American a thing as you can say in front of one of those groups."

Having established that he doesn't believe every structure can be salvaged, Mr. McCallum presented his thinking on approaches to revision of buildings which can be remodeled profitably.

One essential is a broad outline, say a ten-year overview, of what the uses of the building will be, what budget will be available to accomplish the aims outlined, and when the money will be available. A prime consideration is that plans be flexible.

Equally important is a realization that piecemeal modernization is expensive and inefficient. Mr. McCallum encouraged mental hospital administrators to recognize the merit of calling for assistance from local chapters of the American Institute of Architects and thus getting top professional advice. He offered as a companion maxim: Call the architect into your planning sessions at the very beginning; adding that the fees would be about the same, and the architect can help crystallize thinking. Such assistance in long-range planning is already being given in Missouri, and is worthwhile investigating in other places.

Mr. McCallum saw the development of standards as

Participants: *Dr. Philip N. Brown, Mich.; Dr. Dale C. Cameron, Minn.; Mr. Samuel Cohen, N.Y.; Dr. Hayden H. Donahue, Okla.; Mr. R. Bruce Dunlap, Pa.; Mr. Paul J. Elam, Jr., Okla.; Dr. Leo P. O'Donnell, N.Y.; Dr. Benjamin Simon, Mass.; Dr. J. Butler Tompkins, Vt.; Dr. Samuel Wick, Ariz.*

the most important advance in hospital planning. Those set forth by the U.S. Public Health Service have been of great value. But his insistence that these standards are not something which can be reproduced might seem almost paradoxical to the layman. There is so much misunderstanding on this point that he confessed to an emotional feeling about the necessity for elucidating the real function of standards.

"THESE STANDARDS are very, very objective, very thoughtful guides for the over-all planning of all manner of institutions," he said. "But it should always be emphasized that these are not plans to be taken and reproduced; they are more of a stimulus to thought. This is the real value of any set of standards."

He went on to say that the architect cannot generalize. There is no standard plan for any kind of activity. Standards must be adapted and assembled in a particular shape and form for specific use. There was no resistance to this view, for discussion showed that in climate alone, hospital administrators across the country cope with temperatures almost as varied as the two ends of a thermometer.

What criteria can you use to determine whether to demolish or salvage an old building?

This question caused Mr. McCallum to murmur that it covered quite a bit of territory, but he attempted to lay down some broad guide lines. One of the first things to consider is whether conversion to new use is more economical than the construction of a brand-new building. The condition of mechanical equipment in the building—heating, plumbing, ventilating, etc.—is the next thing which should be investigated. The life of the structure of the average building is greater than that of its mechanical equipment.

"A corollary," he said, "is the fact that we demand and expect and by custom introduce a great deal more in the way of mechanical equipment today than we did in buildings of 30, 35, or 40 years ago. So as a first step in modernization you would certainly consider up-dating your mechanical equipment entirely. In most of our institutional buildings today the cost of this portion of a building is somewhere in the order of 25 to 35 per cent, sometimes more, of the total cost of the building.

"THE BEST BRIEF ANSWER I can give is this: First, determine if the building is structurally sound. If it is, and you feel you could spend 35 per cent of the total cost of remodeling on putting in new mechanical and electrical equipment, then determine whether the building has structural features which would prevent such remodeling. And, considering all these factors, determine whether for a little more money you could get a completely new structure."

He recommended setting up a tally, with the good factors in one column, the bad in another; a tabulation of things that can be changed and those that can't be changed; a notation of the things that cannot be changed except at great expense.

Dr. Goshen added that it is important to consider the waste space in the corridors and stairways formerly built into multistoried buildings. "It may reach as high as 25 per cent of the square footage in a building," he said. "When this waste space is eliminated, a one story building may suffice for the same job as a multistoried one."

Mr. McCallum concluded his remarks with this advice: Never forget these three essential considerations: safety; adaptability of space to new needs; and comfort, both physical and esthetic.

Four elements in mental hospital construction claimed the attention of the group in the discussion which followed:

Food service areas.
Heating and air conditioning plans.
Building design geared to care of handicapped patients.
Chapels.

Most controversial of Dr. Goshen's recommendations appears to have been his statement in regard to ward dining areas: "More and more hospitals are finding it desirable in many ways to convert from on-the-ward dining to centralized cafeteria dining. This conversion liberates a sizable amount of space for new uses on each ward."

Exceptions to this statement were taken by doctors and the architect, alike.

Dr. O'Connell cautioned that he would hate to see a swing to the large cafeteria. He feels people can eat much more satisfactorily in smaller groups. He added that our aging hospital population requires more, not less consideration to feeding arrangements for people who cannot leave the ward.

THE ARCHITECT, Mr. McCallum, confessed that he and Dr. Goshen do not see eye to eye on this subject: "I have a terrible horror of congregate dining. This I think is the hallmark of everything that bespeaks the institution to a layman." He included such adjectives as "crowded, noisy, somewhat dirty" in the picture of the inevitable result of such arrangements and protested that eating is *not* "simply a matter of stoking this machine of ours." He believes that the amenities and social graces associated with eating are also important considerations. From the standpoint of economics, he feels there is no clear-cut evidence that small-group eating arrangements must necessarily be more costly. Instead, he pointed out that developments in food transportation with heated carts make distribution from a central kitchen both efficient and economical. Viewing the top number of patients to be served in a single unit as ideally no more than 100, he suggested that such rooms could be used for other purposes after meal hours. Admittedly this meets with a good deal of staff resistance because of the chore of cleaning up involved. Nonetheless, here is a space that should be used more than it is.

The A.P.A. Committee on Rehabilitation has considered the importance of dining areas in patient therapy, Dr. Simon said. He buttressed Mr. McCallum's views on the psychological importance of this, and said he felt they reflected the views of psychiatrists.

Dr. J. Butler Tompkins described results in remodeling a 100-bed admission building to bring about more satisfactory food service. In this case, the service was con-

Osawatomie State Hospital,
Osawatomie, Kansas.
Charles L. Marshall, architect;
Martin K. Eby Construction Co., contractor.

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solidated in one room in the basement to eliminate what had been unsatisfactory service in wards on four floors. The building had no elevator so a large one was installed in an addition to the structure. This made it possible to take all the patients from one ward to meals at one time, and thus serve them better, hotter food. Operating costs were reduced a third, he estimated.

Mr. McCallum's views were sought on the best type of heating when modernization is under consideration. Is a central heating plant preferable? Or should there be individual units for each building? He judged that this was, indeed, a moot question. Until about fifteen years ago no institution considered any plan except a central heating plant. But this poses the problem of getting engineers skilled in the operation of such systems. Concurrently, there has been a tremendous improvement in smaller heating systems, automatic controls making them easy to operate.

ANOTHER CONSIDERATION in heating systems is the type of fuel to be used. In a coal producing area, sentiment in favor of use of a local product will prevail. Abstract advice about types of fuel may find little application.

One definite trend is the use of hot water rather than steam as a heating medium in any sizable building. Hot water systems are less expensive and require fewer fittings and controls. Since steam is obtained only after water reaches 212 degrees F., it imposes more hazards and thus requires extensive shielding. Hot water systems can be modulated much more easily.

Radiant heat, in sources such as radiators or recessed convectors, is somewhat similar to hot water and has the added advantages of maximum cleanliness and ease of cleaning. However, Mr. McCallum cautioned that the radiant heated floor has some inherent disadvantages in that it is not at all flexible in control. Such a large mass of inside air is affected that it is difficult to raise or lower temperatures quickly when climatic conditions change.

Dr. Goshen commented that a good type of heating system can be provided by a combination of radiant slab or floor-and-ceiling heating and forced hot air. You can then have the advantages of both, he said.

DR. BROWN said they have such a combined system at Northville, Michigan. Sixty-five per cent of the heat comes from radiant heat (hot water circulating in the slabs) and thirty-five from heat exchangers in the hot air blowing system. Agreeing that the radiant heating takes longer to bring up to normal heat—they allow 20 days—he finds the combination very effective if used seasonally: In spring and fall they use the blower system, supplementing this with the addition of the radiant heating during the colder winter weather. The single complaint has been from some employees who said their feet were too hot in winter, but Dr. Brown personally did not find this true.

While the north is struggling to keep warm, the south is interested in air conditioning in building design. Once considered visionary in discussions of mental hospitals, air conditioning is gaining acceptance as a practical necessity in hot climates and now ranks second in importance to construction materials that will resist termites.

Mr. McCallum pointed out there is a tendency to install air conditioning piecemeal since the initial cost is less. The obvious disadvantage is the great number of mechanical components that have to be serviced, and the fact that these units have a life expectancy of somewhere in the neighborhood of five, seven, or ten years at a maximum.

Often installation of a proper ventilating system in the initial construction will allow the addition of air conditioning at a minimum expense. Dr. Donahue of Oklahoma underscored this advice. And he saw air conditioning as "the coming thing."

Asked how to eliminate, in a forced air ventilating system, offensive odors emanating from food storage and dining areas, the architect recommended for such areas the introduction and exhaustion of outside air apart from the recirculation system of the rest of the building.

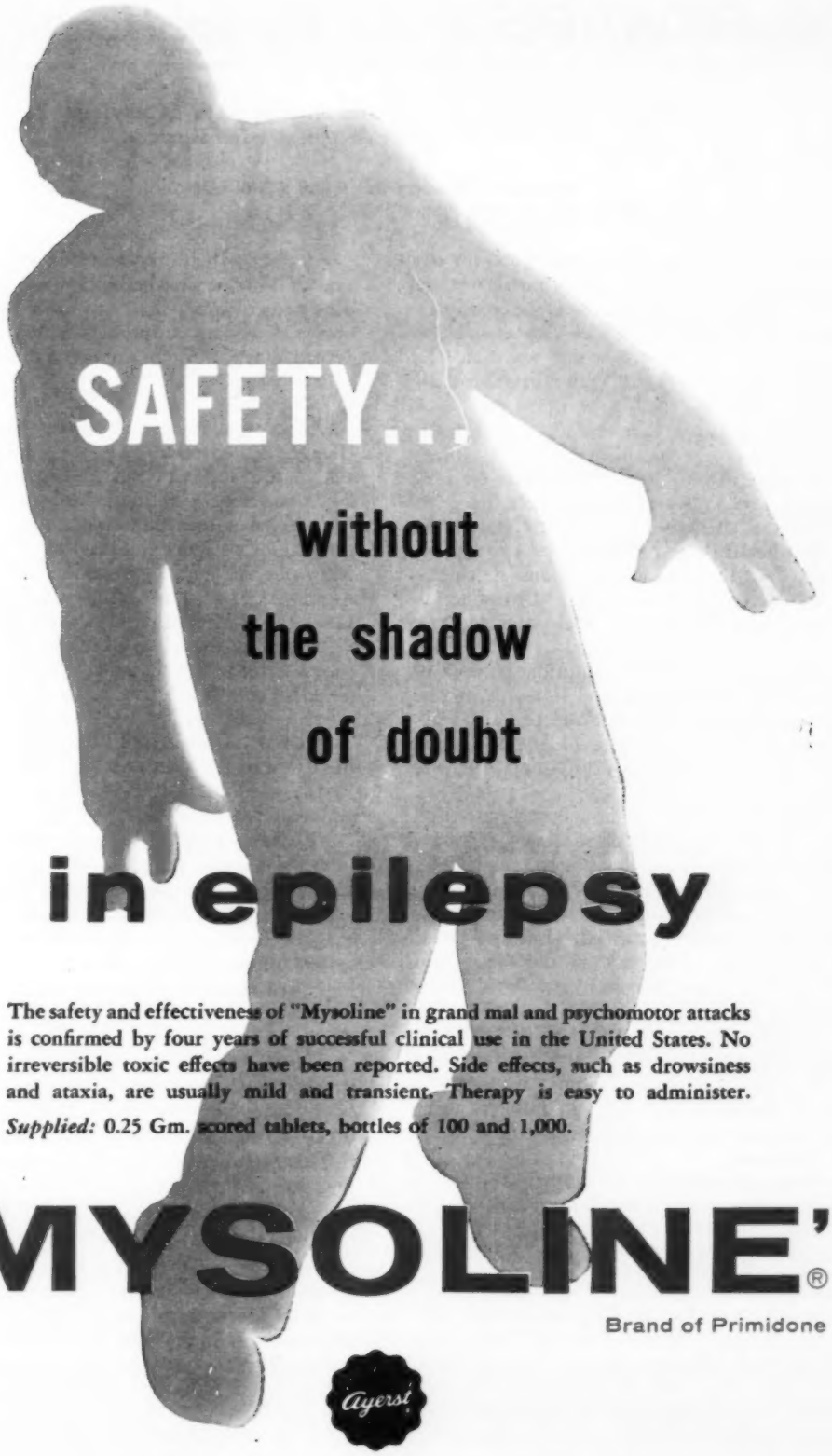
Dr. Cameron asked Mr. McCallum what architects could contribute to designing hospitals better adapted to care of handicapped patients. He replied that a planning guide on how to eliminate hazards to the handicapped is in preparation, and should be ready this winter. For the first time, this will make graphic and statistical facts available on such items as the requirements of people in wheelchairs—for example, proper height of plumbing fixtures. The planning guide is a joint venture of the U.S. Public Health Service, the Conference of Rehabilitation Centers, the Office of Vocational Rehabilitation, and the American Institute of Architects. The guide is being prepared by Professor Sampson of Pennsylvania State College.

A REMINDER of the importance of adapting hospitals to use by handicapped people is certainly in order when reconstruction of a building is under consideration. This is the time to eliminate hazards such as single steps at doors, and short flights of steps. It is generally very difficult to introduce ramps, but simple additions such as hand rails to assist the feeble can make a great difference.

Turning the discussion to a consideration of chapels, Dr. O'Donnell queried whether plans for any future hospital called for small chapels instead of use of multipurpose halls for church services. Another consideration is whether there should be three chapels in a hospital, for the three principal faiths, or whether one building can serve, using three altars on a revolving platform as is done in the armed services.

Dr. Goshen said there are many examples of chapels built with funds raised locally. Legislators are also sympathetic to needs for church facilities, he said. Dr. Brown was dubious about the ease with which such monies could be obtained, saying he has been working for five years to get a chapel.

Dr. Goshen asked for a continuing exchange of success stories in hospital remodeling. He will welcome letters and accounts about reconstruction jobs, and new ideas of special interest can be circulated by publication in MENTAL HOSPITALS. Consultation service is also available through his office.



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NEW FRONTIERS in the Mental Health Effort

The search for new, strange and unusual ways of solving problems interests every hospital administrator.

Discussion Leader: Dr. DALE CAMERON

QUESTION EVERYTHING; assume nothing. Look for new answers and get a research grant to prove whether they are right. Unless we do, there is the possibility mental health concepts may be as incorrect as the once firmly entrenched belief that the world was flat. Dr. Dale C. Cameron, Chairman of this group, urged scrutiny of all present practices.

He reminded his audience that there is a long list of things which we are doing that have no tested validity.

"We have to make assumptions and operate on these assumptions," he said. "But sometimes we have the tendency to assume that the assumptions have been proved. It is a difficult thing to look at one's basic operating procedures and begin to ask questions which may run counter to one's current concepts. Unless we do this, change and improvement are likely to come very slowly."

Dissecting one commonly held assumption, he took up the oft-repeated statement that mental illness is increasing due to increased social pressures, the precariousness of our times, the increased tensions. This idea was presented once to the anthropologist Margaret Mead, who had this to say:

"I am not at all sure that living now is any more difficult than it was in the time when there were five witches down the street. I am not at all sure that our time is any more difficult than when the family who lived on the shore didn't know whether the pirates would come over and burn their house before breakfast. I am not at all sure our tensions are any greater than the family concerned as to whether or not grandmother's head would be taken off before breakfast. I am not at all sure that this well-fed country of ours is in as much difficulty as was the family of many years ago who did not know where the next meal was coming from. As a matter of fact, much of the world still lives in hunger, and I really wonder sometimes if we realize how remarkably fortunate we are."

Dr. Cameron presented further evidence to refute this recurrent statement that mental breakdown is a product of the stress of our times.

Participants: *Dr. Freeman H. Adams, Calif.; Dr. Anthony K. Busch, Mo.; Dr. Jonathan Cole, Md.; Dr. Robert T. Hewitt, Md.; Mr. Robert H. Klein, Ill.; Dr. Francis J. O'Neill, N.Y.; Dr. Thelma Owen, W.Va.; Dr. E. P. Peterson, Wis.; Dr. Arnold A. Schillinger, N.Y.; Dr. William F. Sheeley, Minn.; Dr. C. G. Stillinger, N.Mex.; Dr. Cecil Wittson, Neb.; Father E. J. Zizka, La.*

For years, the Navy admitted psychotic patients—not neurotic—to St. Elizabeths Hospital in Washington, D.C. The rate of admissions per unit of troop strength remained constant from before World War I, through World War I, through the boom of the '20's, and through World War II.

"I WOULD SUBMIT that there were very substantial changes in external pressures during this period of time," said Dr. Cameron. "And yet the rate of breakdown was almost constant during this entire period. In fact, it was so constant that during World War II the number of patients admitted to St. Elizabeths from the Navy per unit of time became classified data. To know this figure and multiply it by the proper factor was to know the Naval strength of the United States."

And so, he challenged, the question stands. Is there a relationship between social pressures and the number of people mentally ill? This is just one example of many, many suppositions frequently accepted as facts.

"I think we need some new methods, some new approaches, to get some answers to old problems," he said.

Congress signified legislative agreement in the principle written into *Title V* of the recently passed Public Health Service Act: *

"The purpose is to make grants to state and local agencies, laboratories and other public and non-profit agencies and institutions, and to individuals, for investigations, experiments, demonstrations, studies, and research projects with respect to the development of improved methods of diagnosing mental illness, and of the care, treatment, and rehabilitation of the mentally ill, including grants to state agencies responsible for administration of state institutions for care, or care and treatment of mentally ill persons, for developing and establishing improved methods of operation and administration of such institutions."

This law spells out succinctly areas in which new approaches are needed.

The discussion chairman pointed out several sacred cows which should be subjected to such scientific scrutiny:

In the area of prevention, mental health education is assumed to be an effective weapon. Ask how effective its methods are and you usually get a count of the pamphlets which have been distributed or the number of times a film has been shown. But can it really be determined that these techniques are effective? Do they really

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* *Title V—MENTAL HEALTH, Special Project Grants, Sec. 501, Sec. 303 of the Public Health Service Act (42 U.S.C. 242a).*

The most outstanding example is the ingenious use made of surplus textiles. Lightweight olive drab wool blanket cloth is made into men's jackets, short coats and shirts which are attractive despite their color. Because the hospital abandoned most of its sewing room operations some years ago in the interests of economy and improved clothing, it had to find some means of having the yard goods made into garments. Mr. Tarumianz hit upon the idea of having a commercial garment manufacturer undertake the job. The Charles Sales Company, of Chelsea, Mass., agreed to try it and the arrangement has worked out satisfactorily for both sides. For the three types of garment mentioned above the hospital furnishes only the blanket cloth—which it gets for 10¢ a yard—and the Charles Sales Company makes it into patient's clothing at a unit price that includes both any extra materials needed and shipping costs. The jackets, which are unlined and have a zipper front cost $2.25 apiece; they require 1¾ yards to make. The shirts are made from 1 2/3 yards and cost $1.80 each. The short coats (three-quarter length) require 3½ yards of cloth since the body is made with a double thickness of cloth for extra warmth; the unit cost of $5.00 includes rayon sleeve linings and a corduroy collar and pocket flaps. The corduroy trim is either brown, dark green or navy, and matching buttons are added.

Dresses Made Also

While most of the surplus textiles are unsuited for women's garments, the hospital does get bolts of striped cotton seersucker for 6¢ a yard. This the Charles Sales Company makes into gripper-front dresses for $1.80 apiece. The same company also takes lightweight khaki cotton twill and cuts it into men's shorts which are sewn at the Delaware State Correctional Institution. Previously the hospital had contracted with the prison to cut and sew the shorts for 25¢ a pair. When Mr. Tarumianz learned that the commercial company's modern equipment could cut the material far more efficiently for 8¢ a pair, he revised his arrangement with the prison. In doing so he saved 2¢ a pair on cutting costs and quite a bit of material. Although a similar split arrangement might prove somewhat more economical for the other garments which the commercial company makes entirely, Mr. Tarumianz feels the professional finish is important for outer garments. Happily, Delaware does not have stringent State Use Laws.

prevent the development of emotional disorders? The speaker saw no good answers to this, but only the need for addressing ourselves to the question.

In this area of pre-hospital care one might ask: How effective are clinics? Who goes to the clinics? Why do they go? And, finally, are people any better off for going as compared with a similar group of individuals who did not have these services? Such a question really flies in the face of a very cherished assumption that we all hold. But when we are asked to demonstrate its truth with experimental data, it is a little difficult.

In the area of the mental hospital itself, the validity of treatment methods brings up the crucial question of how we select appropriate measuring instruments. If one is to compare how effective a hospital is in carrying out its assigned mission of trying to get people well, one needs to know something about how sick the people were who went into the hospital. And we do not have good measures of severity of illness in our field, either in relation to the status of the individual at the time he went into the hospital or in relation to his pre-morbid personality. We say the patient is improved or unimproved. Improved in relation to what? Do we have good measurements for this sort of thing?

The effectiveness of alternative facilities to mental hospitals needs to be weighed: emergency treatment in the home, night hospitals, therapeutic families—that sort of thing. Day care centers are being developed. What kind of patients should go to them? What kind of patients are best treated in them? How effective are they for this type of patient as compared to other methods of treatment?

TRANSITIONAL FACILITIES — half-way houses, sheltered workshops, and other devices in this area should be evaluated.

Post-hospital services should also be put under the microscope of scientific evaluation. What really happens to patients after they leave the hospital? What is the effect of ex-patients' clubs? How could we help general practitioners do a better job?

All of these are areas we make assumptions about. These assumptions prop up our programs, the mental health effort as we now know it. But we do not have much scientific evidence to prove whether our world of endeavor is flat or round!

Two members of the staff of the National Institute of Mental Health, Dr. Robert Hewitt and Dr. Jonathan Cole, participated in this discussion and described how two types of federal research monies can be sought for scientific inquiry.

Dr. Hewitt is concerned with the administration of the program authorized by Title V of the Public Health Service Act. He has a brochure describing the program and telling how to make application for a grant. This can be secured by writing to him at the National Institute of Mental Health, Public Health Service, Department of Health, Education, and Welfare, Bethesda, Zone 14, Maryland.

After an application has been made out and submitted for approval, Dr. Hewitt said, it is referred to a study group made up of professional people from throughout the country. These are all non-government people.

"They review applications thoroughly," he said. "Applications are competitive with regard to attaching priority to them as to which things are the best, which are the most hopeful in the area of care and treatment and rehabilitation of the mentally ill.

"A final decision on their recommendations is made by the Advisory Mental Health Council, which was established to advise the National Institute of Mental Health on many subjects related to mental health. The Council takes the final action on all grants, whether they are Title V grants, grants in psychopharmacology, regular research grants, or training grants. These people meet three times a year. As you may know, there are deadlines in regard to sending in applications."

"This is a rather formidable procedure," one doctor complained. "I would like to ask whether it is possible for a mental hospital staff member with a new idea to go to the National Institute of Mental Health without a lot of red tape, without a lot of difficulty, and get a limited amount of money to carry out a project."

There is a way of getting assistance in making out an application, Dr. Hewitt said. The Department has nine regional offices throughout the country. These offices for the most part are staffed with psychiatrists, psychologists, pyschiatric social workers, and nurses. These people are available to provide consultation. You can also get assistance at the Institute.

"We realize at times it is impossible, because of shortages of personnel and other reasons, to write up and carry out a big project," Dr. Hewitt noted. "However, it is possible to apply for a smaller grant, say to explore an area or to try to develop an idea. Some proposals are very hard to evaluate. But it is possible to get a grant to explore them before it is possible to set down criteria by which they can finally be evaluated. We are very much interested in the small grant idea, and we hope this will stimulate further work and further action."

Some queried whether these Public Health Service grants applied to the adjunctive services, such as music therapy and religion. The answer was that a demonstration or research project in any of these areas would be considered.

IDEAS about practices which need to be assayed occur to everyone. It was felt we should question admission methods, practices which encourage chronicity, and regimes which force the patient into desocialization. Some measure other than the amount of money spent should be sought for the effectiveness of mental hospital care. New patterns of care, such as week-end hospitalization, might be explored. Ways to enhance the patient's feeling of human dignity might contribute to cure. Dr. Cameron suggested research to identify population groups which have an expected high incidence of illness so that preventive techniques could be concentrated rather than scattered broadside on the total population.

Dr. Jacobs saw research design as the stumbling block, state hospital personnel being largely inexperienced in planning and carrying on such work. His idea was that hospital personnel should be encouraged to generate

research ideas, and then a trained research team should be called in to assess the idea, draw up the program, seek and get funds, and carry out the project. Benefits would accrue since well-designed projects would be more likely to produce worth-while results.

Dr. Jonathan Cole is in charge of the program under which funds were appropriated by Congress for the assessment of psychopharmacological drugs. This covers studies of their clinical evaluation, their basic mechanisms of action, effects on psychological functions, and a wide range of other effects. Grants are provided in much the same way as that described by Dr. Hewitt in the case of Title V monies. Assistance would likewise be offered to people who want help in making out applications for funds.

Soliciting cooperation from mental hospital people in this effort, Dr. Cole said: "We are most interested in getting work on new drugs, on old drugs, on almost any kind of drugs which are used in psychiatric practice. Many evaluations are needed. The number of new frontiers in psycopharmacology staggers the imagination."

Asked to spell out some of the drug research needed, Dr. Cole said:

"I would like to describe some projects we now have, showing some of the ideas for which people have gotten support.

"We have two studies in progress now comparing three of the newer drugs in the field. One of our studies concerns chronic schizophrenics who have been hospitalized over two years. Another deals with newly-admitted psychotic patients in state hospital wards. We hope to get some idea of how these drugs compare with each other. Hopefully, we should get some idea as to whether some of them are better for certain kinds of patients than other categories of patients—whether they have any different effects on different types of psychiatric populations.

"We need better measurement devices.

"We are trying to support work in new ways of working with mental patients, new ways of measuring, or at least rating and recording, the way they behave. For example, we have one psychologist working on a twenty-minute interview technique which will provide certain numerical measurements of patients' response. We have acquired adjectives used to describe patients. These will be scored by IBM machines to facilitate collecting and handling data.

"We hope to have a study to look into the question of whether patients who receive drugs and are kept in the community do better or worse than patients who are immediately admitted to the hospital and may or may not receive drugs in the hospital. We have been trying to stimulate outpatient work to see whether one drug is as good as, or better than, another drug or the placebo. So we are interested in a broad range of drug evaluation studies.

"WE ARE ALSO INTERESTED in working out ways of testing. If anyone has any hypotheses, we would be very glad indeed to have them. Some of these may be right, some may be wrong. But you never know unless you figure out a way of running a methodic test."

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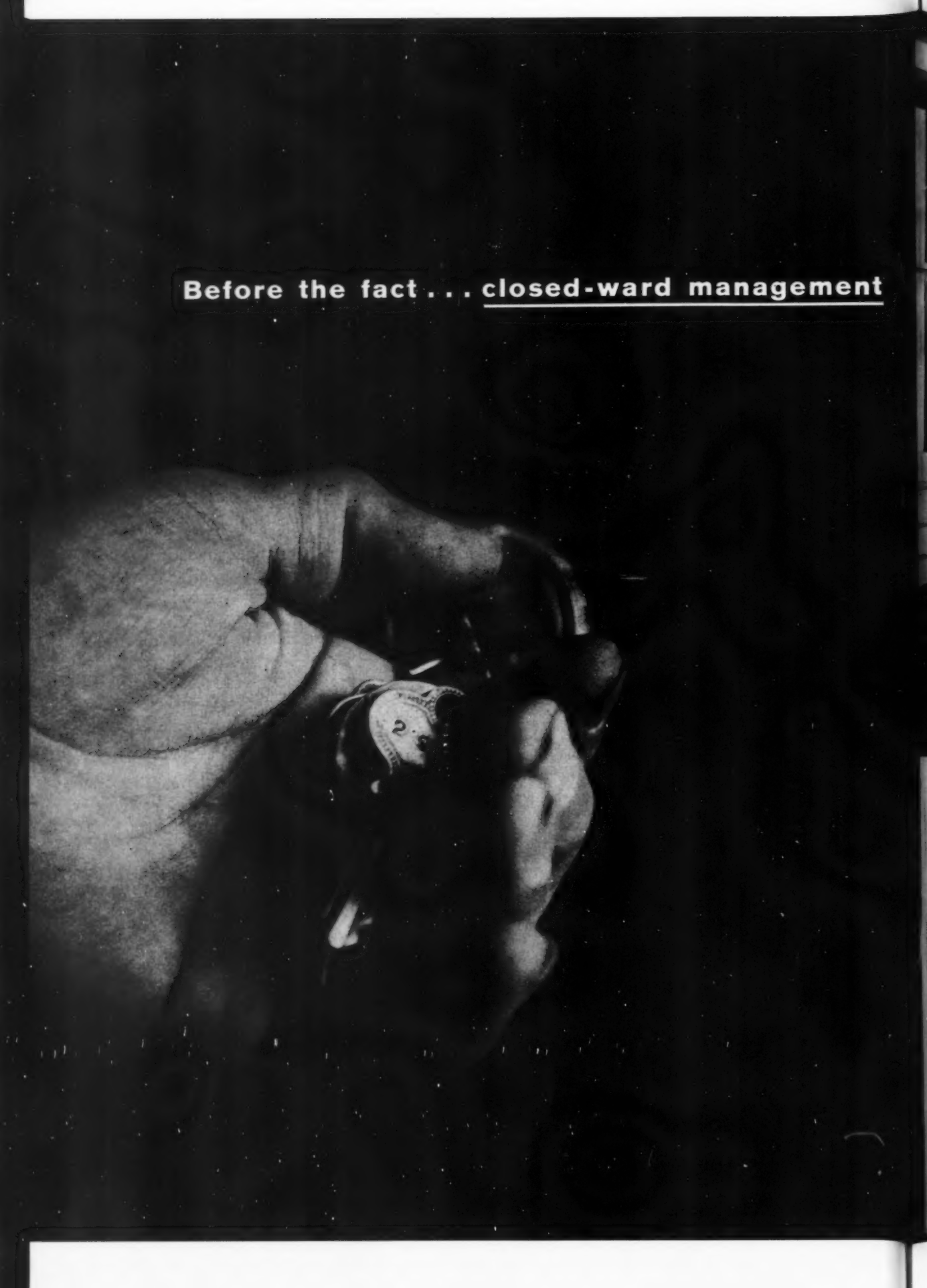
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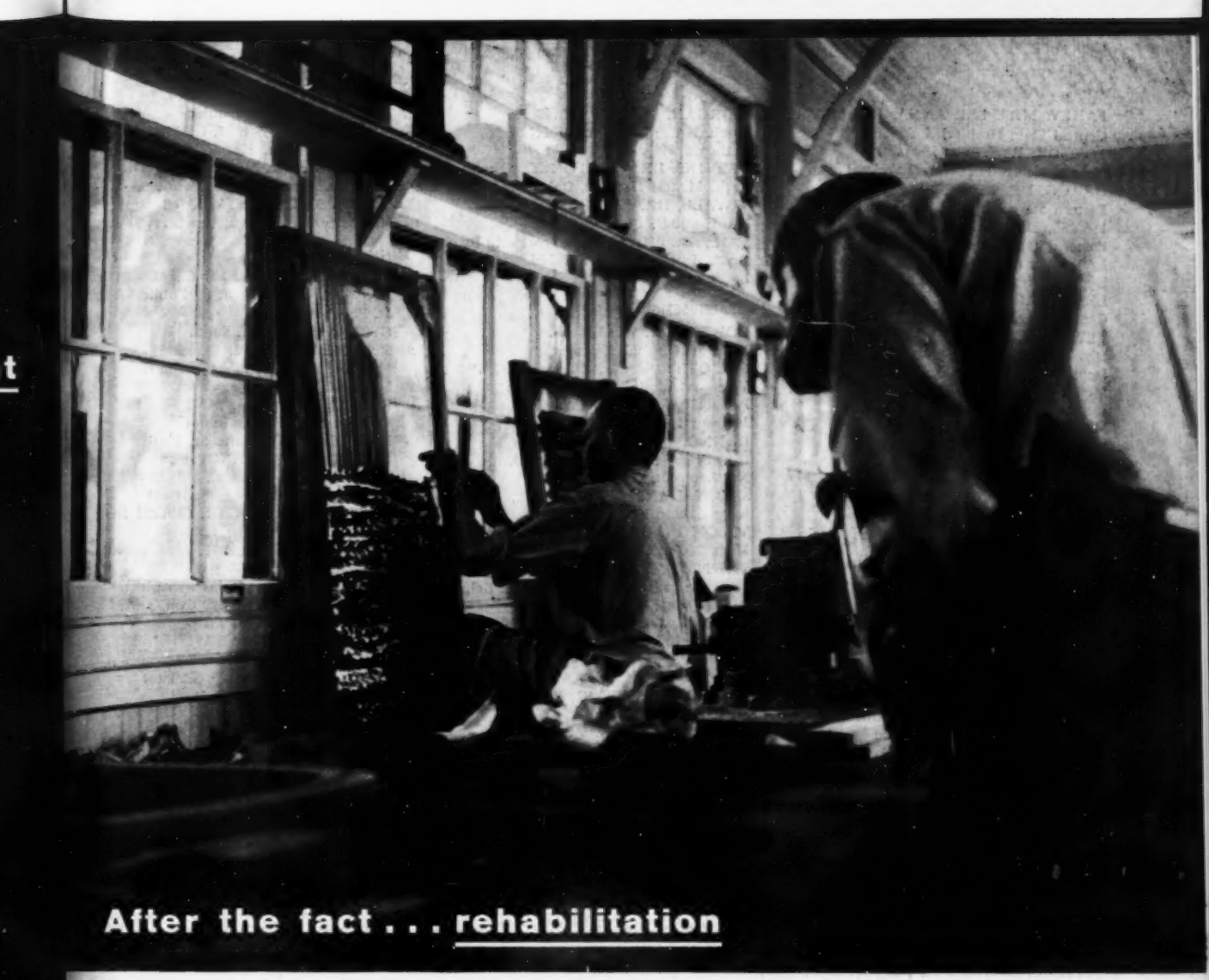

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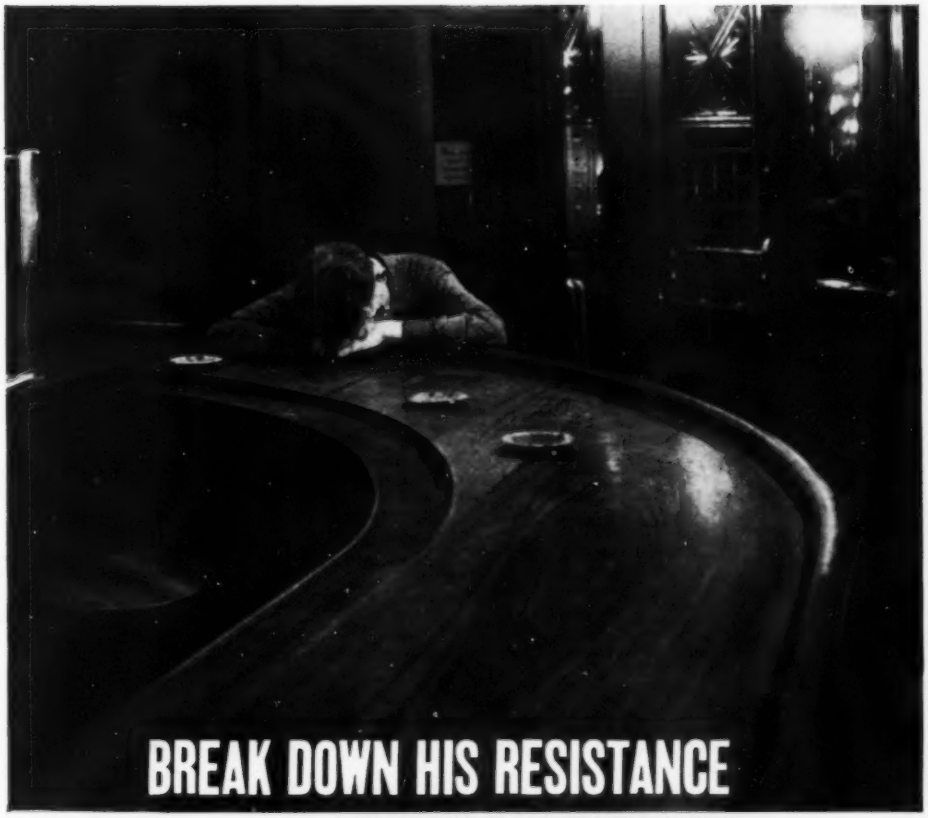

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